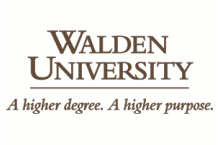

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The Systemic Experiences of Social Workers in an Inpatient, State Psychiatric Hospital

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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2021

Abstract

The Systemic Experiences of Social Workers in an Inpatient, State Psychiatric Hospital

by

Kesia Gwaltney

MSW, Norfolk State University, 2006

BSW, Virginia State University, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Services

Walden University

February 2021

Abstract

The National Alliance on Mental Illness surmised that 1 in 25 (9.8 million) adults in the United States are diagnosed with a serious mental illness annually. Of the 9.8 million people diagnosed, approximately 63% of them are psychiatrically hospitalized with repeat hospitalizations within 1 year of discharge. Social workers play a vital role in the treatment modalities of the patients they serve in the psychiatric hospital; however, there is no research that examined the professional systemic experiences of social workers in state, inpatient psychiatric hospitals and how these experiences may affect treatment outcomes of patients as it relates to frequent inpatient hospitalizations. In this qualitative case study, grounded in systems theory, five social workers employed by a state, inpatient psychiatric hospital were interviewed via video and phone conference. Utilizing thematic-narrative analysis, five themes emerged: (a) insufficient time spent with patients, (b) prioritization of discharging patients and frequent hospitalizations, (c) the levels of support throughout the system, (d) the potential for burnout and job performance, and (e) interactions with patients and commitment to service. The findings of this study confirmed the social workers professional experiences in a state, inpatient psychiatric hospital had an effect on the service delivery to the patients. While the social workers' experiences were a personal journey, there is evidence to suggest some of those experiences were system-driven. This research may bring more open conversations, implementation of much needed initiatives surrounding mental health, and changes in the field of social work and mental health.

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Dedication

This study is dedicated to every social worker that has shown compassion, treated individuals from holistic and person-centered approaches, and understood the importance of the role we play when others diminished our position and shine. Continue to shine bright like the diamonds we are.

This journey is dedicated to my nieces, my godchildren, and all of the children and young adults that call me “Auntie,” “Ms. Kesia,” or “Ms. G.” I want you to know your dreams can be achieved and the sky is definitely NOT the limit…reach as far as your thoughts and imagination will take you! I love each and every one of you deeply!

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Chapter 1: Introduction to the Study

Mental illness is prevalent among all races, cultures, and socioeconomic groups in the United States with 43.8 million (18.5%) adults being diagnosed with any mental illness and 10 million (4.2%) adults being diagnosed with serious mental illness such as schizophrenia, schizoaffective disorder, bipolar disorder, and major depression (Charara et al., 2016). One-half of individuals diagnosed with chronic mental illness begin exhibiting symptoms by the age of 14, and three-quarters begin noticing symptoms by the age of 25 (National Alliance on Mental Illness [NAMI], 2018). Symptoms of mental illness could include paranoia, auditory and/or visual hallucinations, confusion, disorganized thoughts, sleep disturbance, and suicidal ideation (American Psychological Association, 2018). An estimated 5.7 million Americans received inpatient hospitalization with mental illness being their primary diagnosis (Healthcare Cost & Utilization Project, 2015). An individual who is hospitalized is likely to encounter an array of professionals such as psychiatrists, psychologists, and social workers (NAMI, 2019). Social workers often attempt to implement policies and find service providers (psychiatrists, therapists, housing, food services) for those living with mental illness (Shdaimah & O'Reilly, 2016). According to the National Association of Social Workers (2019), social workers make up 60% of mental health professionals. This study examined the professional experiences of social workers in state psychiatric hospitals and how those experiences affected the treatment modalities of patients.

Chapter 1 provides an outline of the study. I focus on social workers and how they are utilized in integrated health care. I reveal the research problem, the purpose of the

study, the research question, and the theoretical framework that governed this study. Lastly, this chapter will discuss the methodology, assumptions, scope of the problem, limitations, and significance of the study.

Background

In the United States, the practice of social work began in 1898 when abuse and neglect of women and children, the maltreatment of the poor, the major influx of immigrants seeking refuge, unemployment, and the stigmatization of mental health were recognized as social problems (National Association of Social Workers, 2019). Jane Addams, known as the pioneer of social work, was one of the first activists who started the U.S. Settlement Houses as a means to assist the community in alleviating poverty, prostitution, overcrowding, and child labor while assisting those living with mental illness and addressing immigration (Ruth & Marshall, 2017). With the assistance of donors and utilizing her own money, Jane Addams started Hull House with Ellen Starr, Julia Lathrop, Florence Kelly, and Mary Van Kleek—all well-educated women. They lived in a home among the poor to build relationships with the women and children to combat the oppression of women and the poor during this economic era (Ehrenreich, 1985).

The roles of social workers have evolved from empowering the underserved to providing clinical interventions, linking individuals with community services, lobbying to change policies, child welfare, and assisting those living with mental illness, disabilities, and substance abuse; however, fighting for social change and advocating for those who do not have a voice has not changed (Rueda et al., 2017). Social workers possess a

trained skillset that allows them to treat individuals holistically (the individual's family, natural supports, and environment) by screening, assessing, managing, and treating environmental factors that can cause a breakdown in the physical, mental, and behavioral health needs of the individuals they serve (de Saxe Zerden et al., 2018). Social workers' role of advocacy, assisting with the development of treatment planning holistically and linking individuals with necessary services in the community is critical for successful treatment, which is why they are a valued member to any care team (Yusof et al., 2019). Research on multidisciplinary teams (interprofessional teams) consisting of the patient/individual, psychiatrist, nurse, psychologist, social worker, vocational/rehabilitation staff, and lead direct support staff, has indicated that these scheduled meetings have a positive significant difference in the treatment outcomes of patients, especially individuals living with mental illnesses like depression and anxiety (Fraser et al., 2017).

Social work practices in a psychiatric hospital focus on the person in their environment and what influences their behaviors systemically, which correlates to social work practices in the community (Sheehan, 2012). Additionally, social workers in psychiatric hospitals and/or mental health facilities link the individual and the community, which often is not easy due to the stigmatization of mental health and the lack of knowledge of how relational and environmental influences affect the psyche (Sheehan, 2012). Additionally, social work practice and treating the individual holistically on the micro (individual) and macro (family, environment, natural supports) levels in the mental health arena is often secondary or low in comparison to

pharmacology instead of using both simultaneously, which may not be as beneficial (Karban, 2017). Further, social workers are responsible for treating all individuals with dignity and respect while addressing their needs (National Association of Social Worker, 2019), but mental health social workers are often expected to ignore their ethics, especially the self-determination of the individual being treated, and stand with the multidisciplinary team in regard to the treatment of patients, including involuntary hospitalizations, which can lead to feelings of defeat and inadequacy of advocating for patients (Wu et al., 2012).

In addition to a conflict with ethics, social workers are at high risk of burnout due to the documentation requirements of daily, weekly, and monthly reports, treatment planning, increased caseloads of 40 or more, and the demands of the job including but not limited to conducting investigations, assisting clients with their needs, and addressing any needs of the agency and clients they serve (Kim & Ji, 2009). Mental health professionals including social workers also have a higher risk of burnout due to ongoing job stress, increased mental separation from the thoughts and views of others through lack of empathy, and feelings of not accomplishing the personal goals such as higher education and promotion (Lanham et al., 2012). Maslach's Burnout Inventory is used widely to research burnout and suggests there are three major components to burnout: emotional exhaustion, depersonalization, and lack of personal accomplishment (Lani, 2010). Emotional exhaustion is the feeling of not having the emotional capacity to exert empathy for others (Trigo et al., 2018). When workers begin to detach their emotions and engage in harmful interactions with others, they are experiencing the depersonalization

dimension of the Maslach Burnout Inventory. Lastly, lack of personal accomplishment refers to not being able to achieve personal goals due to ineffectiveness and low self-esteem (Trigo et al., 2018). Psychiatric health professionals experience high stress levels and burnout when working with the mental health population (Perseius et al., 2007).

The focus of this study was on social workers who work in a state, inpatient psychiatric hospital to address the gap in the literature regarding their experiences and how the system (psychiatric hospital) may be interrelated to those experiences, how these experiences may affect their interactions and treatment with patients, and the reason for frequent hospitalizations. This research added to the existing literature by providing a narrative on social workers' professional experiences in the workplace and whether their experiences directly affect treatment outcomes and modalities of patients. The study will bring awareness to psychiatric hospitals' administrators to consider the practices of the hospital and whether they have resources in place to assist the staff with being more effective in their practices and treatment of patients. In addition, this study explored practices such as allowing patients to be the leader of their multidisciplinary team and addressing issues upfront when they do not meet the treatment modalities and goals set for themselves and limitations on what can be addressed in treatment planning due to the lack of research in these areas (Stevanovic & Rupert, 2004).

Problem Statement

Yearly in the United States, 1 in 25 (9.8 million or 4%) adults are diagnosed with a serious mental illness such as schizophrenia, major depression, and post-traumatic stress disorder (NAMI, 2018). Of those 9.8 million individuals, 62.9% receive inpatient

hospitalization where they are admitted into the hospital for an extended period, other psychiatric services such as outpatient individual therapy, or medication management with a psychiatrist (NAMI, 2018). Upper adolescents experiencing their first psychotic episode, homeless individuals, and individuals with co-occurring disorders (mental health and substance abuse) are considered the most difficult populations in psychiatric hospitalizations (Dixon et al., 2014). Further, 40 to 60% of psychiatric patients hospitalized find themselves repeating the cycle of inpatient hospitalizations (recidivism; O'Connell et al., 2018). This may be due to state psychiatric hospitals utilizing untrained, unlicensed, and uncertified staff five times more than private hospitals, which often results in poor service delivery and inappropriate accountability practices (E-Morris et al., 2010). However, social workers are trained to provide a level of care allowing them to focus on psychosocial needs of individuals while working with individuals on person-centered goals, objectives, and strategies (Lombardi et al., 2019). Depending on licensure and experience, social workers have an abundance of clinical skills that can be utilized to diagnose and treat mental illness, coordinate services, and link individuals with providers and services in the community that assist with the welfare of individuals (de Saxe Zerden et al., 2018). For example, in Virginia, social workers can be a licensed baccalaureate social worker or licensed master's social worker, both requiring successful completion of the Association of Social Work Boards examination. Social workers can also hold licensure as a licensed clinical social worker, which requires a master's degree, 3,000 hours of supervision, and passing the licensed clinical social worker examination (Virginia Department of Health Professionals, 2019).

Although the research regarding the experiences of social workers who work with those living with mental illness in various settings illuminates important findings, I found no research that examined the professional experiences of social workers in state, inpatient psychiatric hospitals and how these experiences may affect treatment outcomes of patients. Given such, further research is warranted that could examine social workers' experiences as it relates to the problem of frequent inpatient hospitalizations of patients (Stevanovic & Rupert, 2004).

Purpose of the Study

The purpose of this qualitative case study was to gain an understanding of how the systemic, professional experiences of social workers in a state, inpatient psychiatric hospital have influenced the treatment delivery of patients. The goal was to address the professional experiences of social workers and how the system of the psychiatric hospital may affect patients, as social workers often work in highly stressful environments (Wagaman et al., 2015). This research can provide a better understanding of personal and professional experiences of social workers in an inpatient mental health facility, whether their experiences directly or indirectly affect treatment modalities of patients, whether their experiences could lead to adverse interactions with patients causing skewed treatment outcomes, and whether the hospital, as a system, affects the work practices of social workers and treatment delivery of patients.

Research Question

How do the systemic experiences of social workers in a state, inpatient psychiatric hospital influence treatment delivery of patients?

Theoretical Framework

The theoretical base for this qualitative case study was systems theory. Systems theory was developed by Karl Ludwig von Bertalanffy to describe how the organization of parts of a system could affect the whole system instead of just the parts individually (Edmonds, 2017). Von Bertalanffy (1972) deduced that individuals are part of the whole; therefore, the organization should be viewed as a whole and not the individual as just a "part." Systems theory became widely utilized during the 19th century by the physical sciences as a methodological approach to understanding an individual holistically (Turner, 1996). Systems theory can be used on an individual, family, or used as a case study. It is an approach highlighting interconnectedness of elements in different settings (Aldwin, 2015). The interconnections that systems theory represent are not considered random, but often replicate patterns that are important and meaningful to those that experience them (Aldwin, 2015). The system of human relationships are the cause and effect of human behaviors (Meyer et al., 2013).

The psychiatric hospital is considered a subsystem and is interrelated with the lives of social workers, although social workers can be viewed as a system on their own. This framework assisted me in viewing the hospital as a system and how social workers were intertwined into that system. Systems theory takes into consideration the roles and expectations of the system and how it impacts the individual involved within the system (Bethea & McCollum, 2013). In this study, systems theory offered a perspective of social workers' lived experiences of being a part of the larger system (psychiatric hospital) and how it influenced the treatment delivery of patients. This study explored the phenomenon

by interviewing social workers who work in the selected environment (state, inpatient psychiatric hospital), reviewing the policies and procedures of the hospital (system), exploring whether they are implemented and have any effects on how social workers view their experiences in the hospital, and analyzing the data to determine themes.

Nature of the Study

The approach to this study was a qualitative, single case study that explored the systemic experiences of social workers at a state psychiatric hospital. The case study was a suitable approach because it allowed each participant to bring a different viewpoint of how their experiences as social workers affected their interactions with patients in addition to other themes, events, and perspectives while allowing me to approach the problem with understanding and explain it in a well-rounded manner (Baškarada, 2014). Additionally, case study research examines the issue through several cases within a common setting. I attempted to utilize multiple sources of information, such as interviews, observations, and documents to collect detailed data (Creswell et al., 2007). However, due to the restrictions of the COVID-19 pandemic, observations and reviewing documentation at the hospital was not possible.

Purposeful sampling was ideal due to the experiences of social workers and their ability to lend their knowledge of the practices of the hospital and patients. Additionally, purposeful sampling allowed me the opportunity to have a reliable sample and provide understanding into the study (Benoot et al., 2016). The type of purposeful sampling utilized in this study was criterion sampling, as social workers had to meet a predetermined criterion to be eligible to participate in this study. Criterion sampling

allowed me to identify any themes in the phenomenon being studied (Palinkas et al., 2015). The criteria for this study were (a) social workers who have day-to-day interactions with patients, (b) have participated in the multidisciplinary team meetings, (c) and were willing to participate in the study. For this research, I had to obtain approval by the hospital's research review committee, and social workers were recruited by obtaining permission from the social work department's supervisor, who sent the approved email and flyer requesting the social workers' participation. I contacted the hospital's research review committee's designated chair via a phone call and follow-up email to explain the study. The instructions requested by the hospital's research review committee's designated chair were provided. To ensure social workers in the study met the criteria, a flyer was created to be distributed via email explaining the study and the criteria that must be met to participate in the study. I requested each participant either call or email to schedule their interview day and time, and a follow-up email was sent to confirm the day, time, and social platform information for the interview. Prior to the actual interview, social workers emailed the signed consent agreement or acknowledged consent indicating their understanding of the study, confirmation that they met the outlined criteria for the study, the confidentiality of their responses, and their ability to have the results of the study once it was completed. I depended on the honesty of the participants of the study.

I attempted to interview six-10 social workers for this study with hopes of reaching saturation with this sample size. Sample size in qualitative studies is smaller than in quantitative studies; therefore, I determined the sample size by using the concept

of saturation (Mason, 2010). In qualitative research, saturation is reached when no new themes, codes, or concepts are found (van Rijnsoever, 2017). Although the recommendation is 25-30 for qualitative studies, case studies, focus groups, and clinical cases can be exempt from this sample size and focus more on the sample size that will provide saturation (Dworkin, 2012). Thus, the sample size for this research study was five social workers.

Thematic-narrative analysis was used to analyze the data. Thematic-narrative analysis can be used with case study, and it allowed me to analyze the phenomenon as it is experienced by the participants (Sahito & Vaisanen, 2018). Thematic-narrative analysis allowed me to address common threads in the interview process and focused on the detailed content (Belanger et al., 2018). There are six steps to thematic-narrative analysis:

1. becoming familiar with the data by reviewing the entire data set several times to ensure that the researcher is fully aware of the collected data,
2. creating the preliminary codes that are basic and interesting to the researcher,
3. extracting the themes by collating the different codes to find the commonalities,
4. looking at the themes from a deeper perspective to ensure that each theme is clear and heterogenous in nature,
5. defining the themes by writing an analysis of the findings for each heterogenous theme that was extracted from the data, and
6. finalizing the written analysis. (Braun & Clark, 2006)

Definitions

Maslach Burnout Inventory – Human Services Survey: The most frequently utilized instrument when assessing burnout (Trigo et al., 2018).

Mental illness: Mental illnesses are health conditions involving changes in emotion, thinking, behavior, or a combination of these, which are associated with distress and/or problems functioning in social, work, or family activities (American Psychiatric Association, 2018).

Multidisciplinary team (treatment team): A team consisting of the patient, the authorized representative, if applicable, and at least one representative from each discipline (psychiatry, nursing, psychology, vocational rehabilitation, and social work) that collaborates to ensure the treatment modalities for the patient are sound, attainable, and measurable (Curtis et al., 2014).

Social worker: Those who assist people with solving and coping with problems (Bureau of Labor Statistics, 2019).

State psychiatric hospital: A state-run inpatient hospital for individuals with mental illness (Reinhardt-Wood et al., 2018).

Unit (hospital): Prearranged sections of the hospital that are inclusive of certain populations being served in the hospital such as gerontology, intensive care, behavioral health, and pediatrics (Grillo, 2019).

Assumptions

The assumptions of this study were that each participant engaged in the study for the purpose of honest research and not because they received monetary gifts or were

persuaded in any way. It was assumed that each participant was honest in their responses and the data were collected ethically and within the confines of the hospital research review committee and university's institutional review board (IRB). Additionally, it was assumed that all data collected and results of the research were free from researcher bias.

Scope and Delimitations

In this study, I examined the professional experiences of social workers and how the system of the psychiatric hospital affected patients. Participants were social workers who exclusively worked in a state, inpatient psychiatric hospital in Virginia and had daily interactions with patients. The sample was small, as this is a case study and could reach saturation with up to 12 participants. This study did not utilize other qualitative approaches in accordance to the topic of research and excluded any other workers in the hospital. The exclusion of other mental health workers was necessary because their interactions with patients and their responsibilities are different than those of social workers.

This study was delimited to social workers working in a state, inpatient psychiatric hospital because there is not a wealth of research on social workers in psychiatric hospitals. However, there is potential for this study to be transferable to social workers that are employed in medical hospitals, hospice care, local and state-level departments of social services, and other entities that employ social workers as well as other mental health workers (psychiatrists, psychologists, and direct care workers).

Limitations

In qualitative case studies, the most common limitations are the lack of validity due to researcher's bias through the interview process, not yielding a sample size that leads to saturation, and being almost impossible to duplicate (Argyrou, 2017). In this study, one limitation was the potential for researcher bias as I was a social worker in a psychiatric hospital. Another limitation of the study was that all social workers were employed by the same organization, potentially decreasing the generalizability of the study findings to all social workers. Further, case studies are often seen as non-research due to them not outlining a specific methodology; however, as long as the researcher had a definitive methodology, can explain why case study was being utilized, and are transparent with any biases that could possibly arise during the research process, a case study is a viable choice (Yin, 2018).

Ethical Considerations

Ethical considerations include confidentiality practices, consent, privacy, and any conflict of interest. To protect the confidentiality of each participant, they were given a personal identification number and their demographics were limited to gender and years of service. Any secondary information I collected (documents, recordings) would have been placed in a locked bag when transporting from the hospital and would remain in the bag when not in use. However, this was not necessary as there were restrictions on visitation to the hospital due to the COVID-19 pandemic. There was not a conflict of interest; therefore, the interview process was completed without any issues.

Significance

The findings of this study have implications for further research and social change in the mental health field. There has been minimal research on experiences of social workers in state, inpatient psychiatric hospitals and how they affected the treatment modalities of patients. This research contributes to current and future literature by chronicling the experiences of social workers working in inpatient psychiatric hospitals and possibly changing how social workers are viewed in the mental health arena such as how they could effect change in the interactions with patients. Additionally, this research could impact the treatment of patients and how hospitals operate in ensuring the inclusion of patients in treatment modalities. The experiences of social workers who work with those living with mental illness in various settings illuminates important findings that have not been examined.

This study could provide insight for several organizations that address the needs of those living with mental illness and those working with them. The National Association of Social Workers could offer workshops and professional development for social workers who would like to work in the clinical setting. Although not addressed in this study, 9.2 million (3.7%) adults in the United States experienced co-occurring mental health and substance abuse disorder (Substance Abuse and Mental Health Services Administration, 2018).

Socially, this research may effect change by providing the necessary data for state psychiatric hospitals to make any necessary changes to the manner in which they conduct practices and the resources that they provide for all direct care staff. This research may

bring more conversation and changes in the mental health field, especially state psychiatric hospitals. Those who work in psychiatric hospitals often see mental illness in the rawest form and need to be in a position where they are offering the best treatment and services for those living with mental illness. This research will be beneficial to the field of social work as mental illness has become a more widespread topic of discussion.

Summary

In summary, social workers are often viewed as disposition leaders because they are responsible for assisting with implementing services in the community for patients once they are discharged from the hospital and may not be considered as part of the treatment process in the mental health arena (Butterworth et al., 2017). They have a crucial role in caring for individuals living with mental illness and are often overlooked in these roles (Fraser et al., 2017). Understanding the experiences of social workers in the psychiatric hospital setting is limited; therefore, this study assessed whether their experiences are affecting the way in which they interact and treat patients. Chapter 2 will provide a synopsis of the literature that counters and supports the problem statement.

Chapter 2: Literature Review

Mental illness is on the rise in the United States with 46.6 million people reported experiencing mental illness annually (NAMI, 2018). Unlike other mental health professionals, social workers are not limited to certain treatment settings and can utilize their clinical abilities outside of the normalized clinical environments (Shafer & Wendt, 2015). However, there is limited research that has explored the experiences of social workers in a psychiatric hospital setting; consequently, the purpose of this qualitative case study was to gain an understanding of how the professional experiences of social workers in a state, inpatient psychiatric hospital influences the treatment of patients and how the system (psychiatric hospital) affects those experiences.

Being a social worker is a stressful occupation due to the guidelines, increased documentation, liability, and the push for measurable outcomes (achieving short term goals that were outlined in the written treatment plan) in treatment modalities (Acker, 2018). Social workers who professionally interact with those living with mental illness also often experience impairment with dealing with the challenges that come with the therapeutic relationship, potentially causing social workers to experience countertransference (transfer of feelings and muddled interactions toward the client) of negative emotions, which can affect the treatment modality and social workers' interactions (Yerushalmi, 2017). Thus, social workers may experience increased distress and decreased job satisfaction (Acker, 2018, para. 2).

There was a necessity for this research study as the literature did not separate social workers independently from psychologists and psychiatrists when working with

individuals diagnosed with a mental illness and in psychiatric hospitals, but the roles are very different. The psychiatrist's role in the hospital is to complete the psychiatric assessment, analyze the patient's history and symptoms, properly diagnose, and prescribe psychotropic medications as deemed appropriate for the patient (Jabbar et al., 2018). Psychologists play a vital role in the treatment of individuals living with mental illness as they offer psychotherapeutic interventions with an evidence-based style, provide psychological testing, and consultation when necessary (Carr & Miller, 2017). However, social workers practicing in the mental health arena focus on the diagnostic, assessment, and treatment needs through individual, family, and group therapy. Social workers treat individuals holistically (individually, environmentally, and natural supports such as family, friends, and employment; National Association of Social Workers, 2019). But there has been limited research on social workers who are employed in state, psychiatric hospitals.

This chapter addresses the literature search strategies followed by the theoretical foundation, systems theory, of the study. Systems theory was chosen as the theoretical foundation to address how the systems of the hospital may influence the experiences of social workers and how they may affect patients' treatment modalities. Furthermore, I attempt to provide a comprehensive synopsis of the literature that outlined the history of psychiatric hospitals, social workers' experiences in the field of working with those with mental health diagnoses, social workers' roles on multidisciplinary teams, and potential burnout. Finally, I provide a summary of the chapter and a brief overview of the following chapter.

Literature Search Strategy

There was a limited amount of literature on social workers who worked in psychiatric hospitals and their roles in this setting. As a result, the following databases were utilized to research peer-reviewed articles: EBSCOHOST, SAGE Journals, PsychINFO, SocINDEX with full text, Social Work Abstract, and Google Scholar. The keywords used to search the aforementioned databases included *social workers, psychiatric hospital, mental illness, social workers in psychiatric hospitals, social workers and mental illness, mental health social workers, mental health, social workers and mental health, mental health social workers, social workers or social services or social work and burnout or occupational stress or stress, frequent inpatient hospitalizations, inpatient psychiatric hospitalizations, frequent inpatient psychiatric hospitalizations, Maslach burnout inventory, burnout and social workers, burnout and mental health social workers, systems theory, general systems theory, multidisciplinary teams, multidisciplinary teams and psychiatric hospitals, multidisciplinary teams and social workers, interprofessional teams and social workers, multidisciplinary teams and social workers and social work and social work practices, history of psychiatric hospitals, history of social work, history of mental illness, history of psychotropic medications,* and *mental illness and treatments.* The reference lists of the reviewed articles were researched for articles of interest; however, the references usually were outside of the 5-year scope. Due to the literature being limited in this area, it was beneficial for me to broaden the search to 10 years instead of the required 5-year span. Additionally, seminal works were utilized to provide a historical overview.

Theoretical Foundation

Systems Theory

Systems theory is the theoretical underpinning for this research study. Ludwig von Bertalanffy is considered the founder of general systems theory, which was developed to support research from multiple disciplines in making scientific discoveries (Rousseau, 2015, para. 1). Ultimately, general systems theory is set on the premise that everything in this world (people, places, and things) belong to a system, which is then broken down into smaller systems that work together to make the system whole (Caws, 2015; Rousseau, 2015). Von Bertalanffy used scientific constructs to explain how behaviors among different systems affect the whole system without realization from those involved in the systems (Caws, 2015). Von Bertalanffy divided systems theory into two categories, open and closed. Open systems are systems exposed to their environments, whereas closed systems are not engaged and are often considered independent (Evans et al., 2014). Most of the behavioral/social and health professions are considered open systems because they often collaborate with other agencies when providing efficient services (Evans et al., 2014).

Since the early 1990s, systems theory in mental health settings often distinguish the personnel in a hierarchical order; however, their function does not always fall into a particular order, and each staff has a perceived notion of where they fall in that order (Juba, 1997). In many organizations, including the psychiatric hospital, hierarchies are applied to ensure all rules and regulations are being implemented. For example, in Virginia, there are nine mental health hospitals that are a part of the Department of

Behavioral Health and Developmental Services; however, the hospitals are accredited by the Joint Commission (Commonwealth of Virginia Department of Behavioral Health and Developmental Services, 2019). Each mental health facility is managed by a facility director responsible for the overall operation of the facility; nevertheless, the treatment is carried out by the multidisciplinary teams (treatment teams) on each unit (Commonwealth of Virginia Department of Behavioral Health and Developmental Services, 2019).

Systems theory is also relatable in a psychiatric hospital setting because of the design of the hospital's function in relation to the direct care staff. Psychiatric hospitals are a part of the system of mental health care for those individuals who need a higher and longer level of care to stabilize their mental health symptoms. The psychiatric hospital can be considered an open system, whereas psychiatry, forensic psychology, rehabilitation, social work, and nursing could all be considered smaller systems that make up the whole system of the hospital. For the psychiatric hospital to enhance service delivery to their patients and create an environment for the direct care staff to give optimal treatment, change must be considered and executed individually, as a multidisciplinary team and as an organization (Ablett, 2019). Understanding the systems created and implementing the change can be difficult and often requires the leadership and multidisciplinary teams to be strong enough to withstand the change (Ablett, 2019).

Utilizing this theoretical framework for this research was appropriate because it allowed me to look at the system and test whether the experiences of social workers are systems-driven. Additionally, it added value to the field of social work by assessing the

importance of social workers in the mental health field, especially psychiatric hospitals, and outlining how the systems in which they work can directly or indirectly affect the populations they serve.

Literature Review

Historical Overview of Mental Illness

According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) by the American Psychiatric Association, mental health disorders are defined as:

> A syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. an expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (p. 20)

Historically, there are three general theories that highlight the origin of mental illness: supernatural, somatogenic, and psychogenic (Farreras, 2019). Supernatural theories, which had been developed prior to the 18th century, suggest that those who have mental illness have been possessed by a demonic spirit or as punishment from a divine

deity (Farreras, 2019; Foerschner, 2010; Kihlstrom, 2002;). According to some supernatural theories, this fear of punishment is a means for the individual to change their "behavior," especially because it is believed that this punishment can be placed on the individual experiencing the mental illness as well as their families (Johnson, 2005). Because many ancient civilizations believed their supreme being was responsible for their family members' mental illness and the deity was the only one who could heal the individual from the illness; thus, prayer, fasting, and other religious acts were means of creating a space for healing (Raguram et al., 2002). For example, the Mesopotamians developed incantations (chants), exorcisms, and other magical ritualistic acts to combat what they believed was a punishment from God (Abdul-Hamid & Stein, 2013; Foerschener, 2010). These beliefs about mental illness dates back as far back as biblical times, being described in the Old Testament of the Bible as "madness" being a punishment from God (Henze, 2001; Porter, 2002). This corroborates the thought that mental illness was an act of the supernatural, which is one theory of the onset of mental illness; however, this has been debunked.

The supernatural theory was dormant for several centuries but arose again in the 13th through 17th centuries when the witch hunt phenomena plagued Europe and America (Farreras, 2019; Schoeneman, 1977). Because witchcraft was considered a form of demonology and populations believed mental illness was demonic and a punishment of God or a higher deity, those living with mental illness who exhibited symptoms, including auditory, visual, and command hallucinations, and other psychotic behaviors, were deemed witches (Schoeneman, 1977). During the witch hunts, most of those living

with mental illness were considered witches or sorcerers and were burned at the stake due to this belief (Schoeneman, 1977). It was postulated mental illness was caused by witchcraft and those living with mental illness were humans used to implement the agenda of the devil (Schoeneman, 1977). By the end of the 18th century, more than 100,000 people, mostly those living with mental illness, had been killed because it was believed that they were witches (Farreras, 2019; Schoeneman, 1977).

Somatogenic theories suggest that mental illness is either hereditary, developed from other internal illnesses, or an imbalance or impairment to the brain (Farreras, 2019). Hippocrates, known as the "father of medicine," dismissed the thought that mysticism and religion were a direct correlation of the ailments of individuals (Missios, 2007). Hippocrates began to dispel the myth that mental illness was caused by the supernatural and religious deities and embraced the fact the universe comprised of four elements: air, water, fire, and earth, which corresponded to the four humours of the body: blood, phlegm, yellow bile, and black bile (Breitenfeld et al., 2014). It was believed the mental illness was exacerbated when the seasons changed and/or when temperatures and humidity changed because the humours would "stir" up the mental illness and determined the level of the mental illness (Evans et al., 2003). Additionally, he believed individuals living with mental illness, nor their families, should be chastened or held liable for their behaviors as expressed through the symptomology of the mental illness (Farreras, 2019). In regard to mental illness, Hippocrates categorized mental illness into three disorders/categories: mania, melancholia (what is now known as depression), and hysteria (often attributed to women who engaged in psychoneurotic behavior and

believed that it was a direct reflection of their uterus, which had to be “moved” or “disinfected”; Breitenfeld et al., 2014). Along similar lines, four categories used by Hippocrates to describe mental illness included epilepsy (a neurological disorder that causes loss of consciousness, sensory disturbances, convulsions or seizures), mania, melancholia, and brain fever (which is now categorized as encephalitis, meningitis, cerebritis, and scarlet fever—all of which are inflammation or infections of the brain; Farreras, 2019).

Galen of Pergamon (130-201 A.D.), another Greek physician, who was influenced by Hippocrates, made historical strides in the study of medicine. For 4 years, Galen studied at a sanctuary where religion, superstition, and healing were intertwined. He also completed an additional 4 years at an Alexandrian school of medicine where he studied anatomy and physiology (Missios, 2007). Although he spent 4 years at a sanctuary of healing prior to attending medical school, Galen also debunked the myth that mental illness was caused by a supernatural or religious deity. He agreed with Hippocrates there were physiological reasons why a person developed a mental illness; however, he introduced the psychogenic theories that suggested an individual developed mental illness due to a physical or somatic reasons but in conjunction with experiencing a traumatic or stressful event, the distortion of their perceptions (delusions), and dysfunctional perceptions to reality (Farreras, 2019).

There were many psychogenic theories related to mental illness and its effects on the mind; however, one of the most popular and widely used theories is the psychoanalytic theory, which was originated by Sigmund Freud (Watson, 1956). The

psychoanalytic theory suggests that the unconscious mind and childhood traumas are a result of how the personality develops into adulthood, which could result in psychological problems. Additionally, this theory suggests that therapy by a psychoanalyst could assist with the treatment of the psychological issue and/or the traumas that occurred (Watson, 1956). Initially, Freud categorized the mind into three regions: preconscious, conscious, and unconscious. Freud believed that the unconscious mind was the catalyst for the development of personality; however, there was a conflict with the preconscious and conscious mind. Thus, the individual's personality was seemingly developed through this mental unrest (Natoli, 2019).

After several years of study and practice, Freud developed a more structured explanation of the psyche, describing how personalities were developed the id, ego, and superego (McLeod, 2017; Natoli, 2019). The id represents the unconscious and primitive system of the development of personality and responds to the impulsivity of a person's needs, desires, and urges; hence, all babies operate in the id until their personalities are fully developed. The ego operates in the conscious psyche, is more rational, and is the system of the personality able to make decisions and problem-solve. The ego often works against the id because instead of seeking immediate gratification, the ego thinks through the consequences of said decision. The superego is considered the moral code system of personality development. Similar to the ego, the superego operates in the conscious mind; however, it assists the ego in making decisions that are considered moral and deflates the urges and immediate gratification of the id. Additionally, the superego allows the individual to engage in behavior and decisions that are considered societal norms

(McLeod, 2017). Freud believed that mental illness was caused by the unconscious and conscious psyches being in conflict with one another, which was the birth of psychoanalytic therapy (Watson, 1956).

Heinz Kohut was an American psychoanalyst who initially followed the works of Freud; however, after many years of working with patients in a psychotherapeutic setting, Kohut began to refute Freud's theory on the id, ego, and superego and developed the theory of self (Kahn, 1985). Kohut postulated the personality was developed through the introspection of one's self. This is developed through two lines of thoughts: birth to the attainment of object love (people) and narcissism through grandiose-exhibitionistic and parent imago lines (Eisenhuth, 1981). In infancy through early childhood, the self is developed by the interactions with the parents (self-object) in an effort to receive what they need. Kohut believed it was parents' responsibility to affirm the child and encourage the child to mirror behaviors. Idealization is the other self-object that is considered in the development of self in which the parents show the child their roles are that of superiority (Eisenhuth, 1981). Kuhot's narcissism line of thought suggested during the mirroring phase of development, the child starts to mature from grandiose and exhibitionist behaviors to working towards realistic goals of success. During this phase, self-esteem is developed through the parents' nurturing and if the parents are empathic towards the child through their behaviors, the child will idealize them (Eisenhuth, 1981). If a person is living with mental illness, it is believed there is a breakdown in the lines of development (Eisenhuth, 1981).

Mental illness and treatments for mental illness date back to 5000 B.C.; however, those treatments were not humane and were often brutal in nature (Missios, 2007; Foerschner, 2010). From ancient times to today, treatments for mental illness spanned from trepanning (the act of drilling a small hole in the skull to "release the evil spirit"), lobotomy, exorcisms, "disinfecting" the vaginas of women with hysteria, isolation, wearing of mystical jewelry, commitment to asylums, chaining to walls, locked in rooms, and medication management have all been means to treat mental illness (Foerschner, 2010).

Psychotropic medications were introduced in 1952 when chlorpromazine was introduced as an alternative treatment of schizophrenia (Blackwell, 1973). Prior to chlorpromazine being introduced, stimulants and sedatives were the only medications utilized to treat mental illness (Blackwell, 1973). Because the medication was found to be successful in managing the symptoms of schizophrenia, other medications, including more sedatives, were created and introduced to treat the symptomology of depression and other mental disorders. By 1965, benzodiazepines, tranquilizers, and other medications were introduced and widely used (Blackwell, 1973). In the United States, prescribing psychotropic medications has grown exponentially over the past two decades and continues to grow annually (Greenblatt et al., 2018; Pincus et al., 1998). With prescribing increasing annually, it can be determined this growth is attributed to a surge in diagnoses, mental illness not being as taboo as it once was, and the desire for those living with mental illness to have a fulfilling life (Greenblatt et al., 2018).

Mental Illness: Fact or Myth

Both Hippocrates and Galen, along with other ancient Greek and Roman physicians and/or philosophers studied mental illness; however, there were some that did not think mental illness fell into any of the aforementioned categories. Factually, there are millions of people worldwide who live with mental illness, but there are some theorists who believe it is mythical (Spillane, 2018). Thomas Szasz is one of the most influential psychiatrists and psychoanalysts that believed that mental illness was a myth (Vatz & Weinberg, 1994). Szasz refuted mental illness was a myth because illness is pathologically defined as only affecting the body and the mind is not considered an organ; therefore, the mind cannot be considered ill (Spillane, 2018; Vatz & Weinberg, 1994). Szasz argued mental illness was a figment invented by psychiatrists to make society believe this is a means of treating people who are simply problemed individuals (Porter, 2002). Spillane (2018) stated, "Szasz's central thesis—that mental illness is a myth—is based on the following reasoning. Illness, by definition, affects only the body. The mind is not a bodily organ (either because it is spiritual in the manner of Descartes, or because as an abstract noun it does not refer to an entity). Therefore, the mind cannot be or become ill, and so mental illness is a myth" (p. 353). Szasz also asserted if the mind is considered the brain, then mental illness is an illness of the brain. Brain illnesses are usually identified through medical standards and symptomology, while mental illnesses are identified through individualized symptoms and behaviors (Spillane, 2018). Additionally, Szasz believed those who wanted to commit suicide had the right to do so.

He was also against involuntary hospitalization for those with mental illness and allowing individuals to plead not guilty by reason of insanity (Sederer, 2019).

There were many people who refuted Szasz's argument; however, one of the most influential contenders was Albert Ellis (Spillane, 2018). He is one person who highly disagreed with and literally debated Thomas Szasz's thought processes about mental illness being mythical. Albert Ellis was a psychologist that believed the total opposite of Szasz and felt mental illness was definitely real (Spillane, 2018). He was the creator of Rational Emotive Therapy, which was a humanistic theory conceptually thought that healthy behaviors and feelings were a result of rational thinking (Backx, 2011; Dryden & Bond, 1994). In the great debate of 1977, Szasz and Ellis had a face-to-face debate to a full audience about whether mental illness was fact or mythical. Ellis's stance was mental illness was a social fact because most people believed it existed and the behaviors exhibited confirmed it was factual (Spillane, 2018). Additionally, Ellis believed psychotic behavior was a result of biological anomalies and neurotic behaviors which resulted from personality deficiencies that were irrational (Spillane, 2018).

Historical Overview of Psychiatric Hospitals

In the 1600s, mental illness was not widely understood by society and was often viewed as immoral, a spiritual "disconnect," or a means of punishment by whatever supreme being individuals believed in (U.S. National Library of Medicine, 2017). One of the oldest and most famous psychiatric hospitals started out as St. Mary of Bethlem Priory in Beckenham, London, which was founded in 1247 and served as a religious house that offered divinity services for those in need and as a shelter for those that could

afford to stay on the premises (McMillan, 1997; Porter, 1997). The first documented patients were 6 people who were labeled as “lunatics” and probably were transferred there from another hospital in Charing Cross (Porter, 1997). It has been documented patients were treated in the most inhumane way. There were concerns with overcrowding, patients being placed in shackles, strait jackets, and other means of restraints, they were not being fed properly, and the leadership was known for making money off of patients and not using the allotted funds to properly care for patients (McMillan, 1997; Porter, 1997). The original hospital was in ruins, so another location was built and they adopted the name the Hospital of St. Mary at Bethlem, which could hold approximately 100 patients. The hospital started to accept individuals living with mental illness from all over the country and, in comparison to other hospitals in other countries, Bethlem was considered one of the most accommodating at that time (Porter, 1997). Every patient admitted into the hospital were given at least one year to be “cured” and they were discharged from the hospital back into society. It was not until 1725 that Bethlem added a unit for those that were “incurable” as they were starting to notice a trend of those not being “cured” (Porter, 1997). Bethlem grew exponentially and the movement for the humane treatment of individuals living with mental illness became a worldwide concern.

In the United States, the Quakers in Philadelphia are credited with being the first to attempt organized treatment of those living with mental illness. Due to the growing trend of individuals with mental illness, in 1753, the Pennsylvania Hospital opened a psychiatric ward in the basement of the hospital that housed approximately six patients initially (U.S. National Library of Medicine, 2017). The need was growing aggressively;

therefore, they had to expand and the Pennsylvania Hospital for the Insane was erected in the suburbs in 1856 and remained opened until 1998 (U.S. National Library of Medicine, 2017). In 1770, Virginia was facing the same concerns with their mentally ill population, which prompted legislature to pass a bill for them to build a hospital in Colonial Williamsburg near the College of William and Mary. In 1773, Eastern Lunatic Asylum, now known as Eastern State Hospital, was admitting their first patients and is nationally known as the first public hospital to specifically treat individuals with mental illness and remains open to date (Commonwealth of Virginia Department of Behavioral Health and Developmental Services, n.d.).

Dr. Benjamin Rush is known as the "father of American Psychiatry" and is credited for acknowledging mental illness as a disease instead of punishment of the person and their family (Penn Medicine, 2017). From 1752 – 1817, Philadelphia, Virginia, New York, and Kentucky were states that were the firsts in providing treatment to those living with mental illness and by 1890, every state had public mental health hospitals known as asylums (U.S. National Library of Medicine, 2017). These asylums were the principal mode of treatment of the mentally ill, but the treatment of the individuals and the actual asylums were inhumane and deplorable (Modak et al., 2016). By 1840, many of the institutions were overcrowded and patients were often mistreated by being placed in straitjackets, being physically abused, malnourished, chained, lacked hygienic practices, were placed in insulin-induced comas, given lobotomies, and underwent electroshock therapy, which increased the behaviors and symptoms of mental illness (Modak et al., 2016). In 1844, the Association of Medical Superintendents of

American Institutions for the Insane was founded by a group of 13 physicians who aspired to increase their knowledge of mental illnesses, how they can be classified as diseases, and improve the treatment of and for those living with mental illness (Colaizzi, 2005).

Psychiatric care has evolved towards better patient care and a better understanding of the manifestation and treatment of mental illness due to the efforts of Dorothea Dix. She is considered a forerunner in the way society views those with mental illness (Strickler & Farmer, 2019). Due to her own mental illness of depression and a "healing" through individualized therapy, Dix decided to work in a prison where she witnessed individuals with mental illness be treated inhumanely. This prompted her to lobby for inmates' rights in several states and to improve how those living with mental illness were treated. Additionally, she was responsible for lobbying for and the opening of 32 of the 123 mental health hospitals during the 1880s (Strickler & Farmer, 2019).

Another frontrunner in the change of how those living with mental illness were treated was Clifford Whittingham Beers. He was the founder of the Mental Hygiene Movement after he was committed to 2 asylums and 1 state psychiatric hospital on three different occasions due to his attempted suicide and symptomology in 1900 (Moldovan, 1954). This seminal work by Moldovan (1954) outlines how Beers was mistreated in each location and how he ultimately became well enough where he recorded on paper how deplorable the conditions of the institutions were. Beers would provoke the untrained staff so they would place him on the most violent units, so he could see how patients were treated there (Moldovan, 1954). Upon release from the hospital, Beers was

able to write his book outlining his and other patients' experiences in the hospital. His book prompted the development of the Mental Hygiene Movement in 1908 in Connecticut. By 1909, the local movement became a national phenomenon and the National Committee of Mental Hygiene was formed (Moldovan, 1954). In the Commonwealth of Virginia, where this study will take place, there are eight state affiliated mental health hospitals for adults and one for children and adolescents (Commonwealth of Virginia Department of Behavioral Health & Developmental Services, 2018). Virginia is the home of one of the oldest psychiatric hospitals still in operation today (Commonwealth of Virginia Department of Behavioral Health & Developmental Services, 2018).

Today, psychiatric hospitals are often divided into several different wards or units in accordance to the level of care that is necessary for patients admitted for care (Papoulias et al., 2014). The purpose of the wards or units are to provide a therapeutic environment for patients, safety, offering a milieu that is conducive to symptom management, and preparing patients for discharge into the community (Papoulias et al., 2014). A systematic review of the literature completed by Papoulias et al. (2014) included quantitative, qualitative, and mixed methods studies to evaluate how therapeutic the wards or units were for patients that were served and discovered there were links to symptoms, social interaction, restraint and seclusion, the overall atmosphere, and the perceptions of the staff and patients that work and live in the psychiatric hospital. Many psychiatric hospitals are implementing more recovery-oriented care within the confines of their treatment modalities as this promotes individuality of care by utilizing a strength-

based perspective for patients that inherently creates a sense of hope, structure, and empowerment (Chang et al., 2018). Recovery-based care allows the practitioners and patients to focus on taking personal responsibility of their mental and physical well-being, while concentrating on their independence and being motivated to reach their potential (Chang et al., 2018). While recovery-oriented care has been a movement in the psychiatric hospitals, trauma-informed care has been on the horizon as well. Levenson (2017, p. 105) defines trauma "as an exposure to an extraordinary experience that presents a physical or psychological threat to oneself or others and generates a reaction of helplessness and fear." Trauma-informed care hinges on the thought most people have experienced some form of trauma in their life, acknowledging the symptomology of the trauma, and how that trauma may directly or indirectly affect the person's life and the choices they make (Sundborg, 2019). The role social workers play in trauma-informed care in a mental health setting is they are trained to recognize the patient's environment could be a direct correlation to the trauma the individual has experienced; therefore, ensuring the patient's treatment modalities are determined from a holistic perspective is vital (Levenson, 2017).

With the works of Hippocrates, Galen, and other physicians that worked with those living with mental illness, the views and treatments of mental illness has vastly changed. With the addition of psychiatric hospitals and more physicians that specialize in mental illness (psychiatrists), medications were introduced and are more widely used in the treatment of mental illness. Psychotropic medications were introduced in the 1800s and are widely used today. Psychotropic medications started with the use of insulin,

barbiturates, and bromides for sedation and then graduated to lithium in the 1940s and now the medications that we have today (Foerschner, 2010; Stephenson et al., 2013).

Frequent Inpatient Psychiatric Hospitalizations

After the initial discharge from a psychiatric hospital, it is expected at least 40% to 60% of those patients will be hospitalized again within one year of discharge (O'Connell et al., 2018). There are not any definitive answers as to why the recidivism rate amongst those that have been admitted into an inpatient psychiatric hospital remains high; however, a qualitative study of forensic patients from an inpatient psychiatric hospital indicated the overarching themes of frequent hospitalizations or reoffending (which is a strong indicator of rehospitalization) were time to make changes in their behavior or believe they should not be in the hospital at all, trust and the building of meaningful relationships of healthcare workers and other patients, the hope and belief they will be effective in their treatment in accordance with their outlined treatment goals, developing the necessary tools, and having the resources available to be successful through and after treatment (Pollak et al., 2018). Contrary to the aforementioned study, a systematic review of the literature revealed significant predictors of psychiatric rehospitalization was related to the patient's lack of compliance with medication regimen and doctor appointments after discharge, the type of housing they were discharged to with evidence being discharged to their own homes created better outcomes, but did not prevent rehospitalization, and the co-occurring disorder and diagnosis of substance/alcohol abuse (Sfetcu, et al., 2017).

Like frequent inpatient hospitalizations, length of stay while in the hospital is also a factor for those living with mental illness (Pauselli et al., 2017). With deinstitutionalization being a primary focus on the care of those living with mental illness, it is recommended inpatient hospitalizations be as brief as possible while providing care beneficial to the patient (Pauselli et al., 2017). A quantitative study conducted by the aforementioned authors yielded findings that indicated predictors of longer length of stay in the hospital was attributed to a single/unmarried marital status, involuntary admission, being admitted with a primary diagnosis of a thought or mood disorder, no prior diagnosis of substance use disorder, those diagnosed with schizophrenia and/or other psychotic disorders, the patient being prescribed three or more antipsychotic medications, and the patient being discharged to a residential facility and not simply to their home (Pauselli et al., 2017).

Social Workers and Mental Health

Social workers are educated and trained to advocate for those individuals who are considered disregarded by societal norms and includes, but are not limited to minority groups (Bowen & Walton, 2015). In the mental/behavioral health field, the role of social workers is highly significant due to the primary ethical tenets of promoting human and client rights, person-centeredness, advocacy, and effective interventions to decrease symptomology of those living with mental illness. Their role consists of assisting individuals with complex lives with cultivating their sense of purpose. Additionally, social workers understand the importance of working with an individual holistically and within systems (the individual, environment, and natural supports); therefore, they have

the ability to engage those that may be living with mental illness and other health concerns (Bowen & Walton, 2015; Courtney & Moulding, 2014; Hussein, 2018). Although there is relatively little research on social workers in psychiatric hospitals and their experiences, there are few studies focused on mental health social workers in community mental health settings and how recovery-oriented care of patients affected the ethical practices with involuntary patients (Courtney & Moulding, 2014), the importance of educating mental health social workers and community mental health nurses to combat the growing need of those practitioners because of the rise of mental health concerns (Beinecke & Huxley, 2009), and the need of mental health social workers on multidisciplinary teams to provide the necessary psychoeducational needs, assessments, and working with individuals and families from a holistic approach (Yusof et al., 2019).

In review of the aforementioned studies, there is growing support for the claim there is a need and importance of social workers in the mental health arena; however, none such authors discussed the professional experiences of social workers in those community-based environments (Bowen & Walton, 2015). Although the professional experiences will be addressed in this study, the personal aspects of the social workers' lives could also be a factor as their own mental health, substance abuse and use history, and past life experiences could play a role in how they interact with their patients (Pooler et al., 2008). Despite the Social Work Code of Ethics being the guide to how social workers are supposed to conduct themselves with clients, if they do not receive the necessary training to be emotionally aware, seeking help when needed, and

understanding their reasons for being in the profession, the ability to be effective in their scope of practice becomes more challenging (Pooler et al., 2008).

Effectiveness of Social Workers on Multidisciplinary Teams

Multidisciplinary teams consist of a group of professionals from different disciplines, along with the individual being served, the family, and any outside agencies that are assisting with the treatment of the individual being served work together to develop care plans for the individuals they serve (Ambrose-Miller & Ashcroft, 2016; Burden & Thornton, 2018). Multidisciplinary teams can be found in most clinical, physical, and behavioral health settings (Giles, 2016; Yusof et al., 2019). Typically, in psychiatric hospitals, especially in Virginia, multidisciplinary teams are led by the patient; however, amongst the disciplines, the psychiatrist is the leader of the team with input from the other professionals on the team (Goldberg et al., 1984). These meetings are a requirement from the regulatory agency that ensures the hospital's adherence to the regulations they must follow (Curtis et al., 2014). As with any other team-driven service, there can be concerns with how the team facilitates treatment modalities. According to the Interprofessional Education Collaborative, there are four competencies that should be considered on a practicing multidisciplinary teams that would yield success (Ambrose-Miller & Ashcroft, 2016). The competencies include implementing morals and values for successful practice, outlining and understanding the roles and responsibilities of each member of the team and the team as a whole, having open communication amongst the team, and collaborating as a team (Ambrose-Miller & Ashcroft, 2016). Studies suggest the presence of mental health social workers, especially on multidisciplinary teams, is

vital to the care of patients (Giles, 2016). Social workers can advocate for patients by observing how medications affect their day-to-day interactions, providing individualized interventions, treating the patient from a holistic approach, and the coordination of effective discharge plans that will assist the individual and families with after-care (Giles, 2016; Yusof et al., 2019).

Although considered valuable to the multidisciplinary team and the care of the patients, social workers often experience feelings of inadequacy by those on the team perceived as having a higher status or leadership of the team, thus enforcing decisions that may not be all-encompassing of the entire team (Atwal & Caldwell, 2005). Despite this periodic practice, studies have indicated social workers often experience feelings that their roles on the multidisciplinary team are more routine and forces them to focus less on the emotional and personal needs of patients and more on the practices of the hospital (McLaughlin, 2016). Similarly, the study implemented by Ambrose-Miller and Ashcroft (2016), the authors found there were challenges faced by social workers on a multidisciplinary team. Majority of the themes that emerged from their study aligned with the competencies outlined by the Interprofessional Education Collaborative, in addition to discrepancies in which team member has the final decision-making power (Ambrose-Miller & Ashcroft, 2016).

A mixed methods study conducted by Sohn and Jang (2019) concentrated on the experiences of social workers and how collaboration (case management) with other agencies and disciplines to assist those living with mental illness meet their treatment needs. Quantitatively, the researchers utilized a spreadsheet to have the participants to

record their activities and those were analyzed using descriptive statistics analysis and SNA. While qualitatively, focus groups were used, the research revealed there was poor collaboration with the other agencies, which is not effective for the clients' treatment (Sohn & Jang, 2019). Secondly, the lack of resources and the idealistic expectations to achieve optimal job performance. Lastly, there was a need for a more centralized system that would foster a more collaborative, organized manner in which case management services are implemented (Sohn & Jang, 2019).

Burnout of Social Workers

Burnout can affect any person in any profession and is defined as a person's response to the pressure and stress of their occupation which can be brought on by disproportionate work demands, the monotony of the job tasks, conflict, accountability practices, lack of professional development opportunities, and work/life balance (Marc & Oşvat, 2013). Job stress, high demands, consistent documentation, outrageous caseloads, inadequate wages for the workload, lack of proper supervision, hopelessness surrounding personal goals, and detachment from human emotion are some of the reasons why social workers are at a high risk for burnout (Kim & Ji, 2009; Lanham et al., 2012; Travis et al., 2016). Lizano (2015) argued burnout started with the human services sector because of the high rate of workers experiencing fatigue and feelings of being overworked due to the needs and demands of the populations they worked with. Additionally, those that work in the human services field, along with 6 other professions, have the worst physical and psychological health and job satisfaction amongst 26 surveyed professions (Lizano, 2015). As highlighted by Hussein (2018), social workers engage with those that have

experienced trauma, abuse, poverty, and other life altering events. This causes social workers to be at an unprecedented level of stress and burnout than any occupation in the human services field. Morse et al (2012) reviewed several studies and concluded 21-67% of mental health workers, including social workers, experienced burnout at extremely high rates. Burnout can be costly for employers as staff self-terminate their positions, the employers have to hire and train new staff to be efficient (Morse et al., 2012).

Maslach Burnout Inventory (MBI) is an instrument that is widely used throughout studies addressing burnout by utilizing a survey that covers 22 items related to occupational burnout. When analyzing the Maslach Burnout Inventory, the three major theoretical assumptions measured are emotional exhaustion, depersonalization, and low personal accomplishment (Lani, 2010; Tartakovsky, 2016). Emotional exhaustion is the employee's inability to feel and display emotion when working with clients (Savaya et al., 2018; Tartakovsky, 2016). Depersonalization is when they start to view the clients they encounter negatively and their interactions are pessimistic (Savaya et al., 2018; Tartakovsky, 2016). Low personal accomplishment makes the employee feel dissatisfaction with their professional growth and have an overall undesirable insight of their job (Savaya et al., 2018; Tartakovsky, 2016). Because those living with mental illness are viewed as vulnerable, stigmatized, and often a misunderstood population, social workers that provide services to them are at a higher risk of emotional fatigue; thus, causing a higher level of burnout and stress (Bove & Pervan, 2013; Hussein et al., 2014a). In a quantitative study completed by Hussein (2018), the findings indicated overall, social workers have a moderate to high burnout rate in accordance to the Maslach

Burnout Inventory. For social workers who primarily work with children and families, their burnout is more associated with depersonalization because of the multifaceted social problems, such as poverty, removal of children from the home, homelessness, abuse and neglect, adoption, foster care, and chronic illnesses, of the child and the family; however, social workers that primarily work with adults and those with mental illness were found to have less emotional exhaustion and feelings of depersonalization. The key finding of this study is that the burnout of social workers is directly related to how they perceive their work environments, the resources available to them, and the demands of the job. Another quantitative study conducted by Sofology et al (2019) found emotional exhaustion and personal accomplishment were significant for mental health workers. Also, there was a direct correlation with workers' length of time on the job and emotional exhaustion. The longer the worker stayed on the job, the likelihood of developing emotional exhaustion was higher. This level of emotional exhaustion led to insufficient job performance (Sofology et al., 2019).

Social workers have to feel like they have support of the organization employing them by including them in the decision-making processes, proper supervision, and a culture for learning (Hussein, 2018). It is imperative employers of social workers be cautious of the effects of burnout because it can be detrimental to the productivity and the quality of client care, treatment modalities and outcomes, and social workers' overall physical and mental health (Sofology et al., 2019; Tartakovsky, 2016).

Summary and Conclusions

Although there has been research to address social workers and burnout, the importance of social workers in the mental health field, and social workers' roles in community-based care in conjunction with recovery-themed care (Yusof et al., 2019; Beinecke & Huxley, 2009; Courtney & Moulding, 2014), there is no research to address the systemic experiences of social workers that are employed in state psychiatric hospitals and the influence of these experiences may or may not affect the frequent hospitalizations, interactions, and treatment modalities of patients served. Given such, further research is warranted that will address the aforementioned phenomenon. Through extensive research in the databases offered, literature on social workers in psychiatric hospitals was limited.

The principal reason for this qualitative study was to investigate the experiences of social workers in a psychiatric hospital. Additionally, the contribution of this study brought awareness to the psychiatric hospital's administrators to consider the practices of the hospital and whether they have resources in place to assist social workers and other direct care staff with being more effective in their practices with patients. The results of this study garnered more awareness of the effects of working with those living with mental illness and how to effectively give self-care and self-awareness. It is with great hope this research brought more conversation and changes in the mental health field, especially the state psychiatric hospitals. Chapter 3 addresses the research methodology, design, and rationale.

Chapter 3: Research Method

The purpose of this qualitative case study was to gain an understanding of how the professional experiences of social workers in a state, inpatient psychiatric hospital influenced the treatment of patients whom they serve and how the system (psychiatric hospital) affected those experiences. The goal was to address the experiences of social workers in relation to the effects they have on patients. Social workers often work in highly stressful environments and are expected to provide quality support to the individuals they serve (Wagaman et al., 2015). This research was conducted to gain a better understanding of whether social workers' personal and professional experiences in an inpatient mental health facility directly or indirectly affected the treatment modalities of patients, led to adverse interactions with patients that caused skewed treatment outcomes, and whether the hospital, as a system, affected the work practices of social workers and the treatment delivery of patients.

Research Design and Rationale

Research Question

How do the systemic experiences of social workers in a state, inpatient psychiatric hospital influence treatment delivery of patients?

Research Design and Rationale

The research design to this study was a case study, which allowed me to analyze the research question from a holistic approach (Baškarada, 2014). Additionally, a case study allowed me to explore the phenomenon in more detail and how or why it occurs (Campbell, 2014; Yin, 2018). There are five research methods utilized in social science

research—experiment, survey, archival analysis, histories, and case studies—all of which ask a combination of "who, what, when, where, and how" and are differentiated by three conditions to determine which method to use (Yin, 2018). The conditions are: (a) how the research question is developed, (b) the control the researcher has on the behavioral events, and (c) determining whether the research will focus on current or historical events (Yin, 2018). Experiment method usually requires the researcher to conduct a trial or test that has a research question that asks how or why. Survey method is used when the researcher is using a questionnaire to analyze a phenomenon of study. Archival analysis utilizes documentation/data that has been used to analyze a particular phenomenon and when the researcher is seeking the prevalence of said phenomenon. Historical analysis is when the researcher is utilizing seminal data and other documentation to determine how and why a phenomenon is viewed (Yin, 2018).

Case study was utilized for this study because I was seeking to explore how the professional experiences of social workers in a system (psychiatric hospital) influenced the treatment modalities of patients. A case study allows the researcher to examine the contexts of experience such as social and political contexts (Njie & Asimiran, 2014, para. 9). Case study was the more appropriate qualitative design because I explored in-depth data about this particular group.

Role of the Researcher

In qualitative research, the researcher is considered the key instrument and has an influence in the research process (Moser & Korstjens, 2017). The researcher has many roles in the research process and must be able to identify their positionality in the

collection of the data (Ravitch & Carl, 2016). For instance, researchers can be considered observers while interacting with the participants, as they need to be able to perceive when the content of the interview process may be too emotional for the participants. Researchers should be empathetic to the needs of the participants as it is a means of building rapport and trust (Moser & Korstjens, 2017).

As the researcher, I collected and analyzed the data and was dedicated to understanding the data to ensure richness. Qualitative research must be trustworthy and can only be established through credibility, transferability, dependability, and confirmability (Amankwaa, 2016). Credibility reflects whether there is any truth in the findings of the research and can be established through extended interactions with the research participants through observations and interviews, the use of different data sources, and member checking (Amankwaa, 2016). Transferability is the extent to which the findings can be transferred to other settings, situations, and populations, which is provided through descriptions of the participants and the study (Connelly, 2016). I ensured all details of the study were outlined in manner where the readers, both lay and professionals, have a full picture and understanding of the study to provide a level of transferability in future qualitative studies. Dependability of the study references how stable the conditions and data are over time (Connelly, 2016). To evaluate accuracy of the data, I allowed a fellow researcher not involved in the actual research to conduct a review of the research process. A study can be considered dependable if the researcher's processes and descriptions can be duplicated in future studies (Cope, 2014), which was confirmed by allowing the processes to be reviewed by another researcher.

Further, reflexivity is the researcher's introspective assessment of their identity through the research as well as any biases that may arise (Wendel et al., 2018). This process requires self-examination frequently throughout the study to ensure that researcher's subjectivities do not impede on the results of the study (Ravitch & Carl, 2016). As a qualitative researcher, bias can alter the authenticity of the participants' experience and misrepresent what the participant was attempting to convey (Wadams & Park, 2018). I am a social worker by education and was employed at a state psychiatric hospital in that role. Even though I had experiences in the position, exploring the experiences of other social workers in a state psychiatric hospital was beneficial for the field. There was a potential for unintentional bias because of my understanding of the environment and the job functions; however, due to the amount of time I had been separated from this role in a psychiatric hospital (5 years), it did not pose any threat for bias in the research. When conducting the interviews, I also focused on gaining the participants' understandings, feelings, and discernments and circumvented trying to influence the answers to align with my purview (Moser & Korstjens, 2018). There was not any conflict of interest or ethical concerns.

Methodology

Participant Selection Logic

For this research study, the recruitment process consisted of contacting the hospital's research review committee designated chair via email and formulating a request to conduct the study. All documents requested by the research review committee's designated chair was submitted. Participants were selected through the

following criteria: (a) be involved in the day-to-day interactions with patients, (b) participated in multidisciplinary team meetings, and (c) were willing participants in the study. Purposeful case selection was ideal due to the experiences of social workers and their ability to lend their knowledge of the practices of the hospital and patients.

I utilized a purposeful sampling method, which allowed me to select the sample size that irradiated what is being studied (van Rijnsoever, 2017). When selecting a sample size, there was not a specific guideline to suggest what a sample size should be in qualitative research (Nelson, 2016). However, qualitative studies often have a smaller sample size than quantitative studies and must reach saturation to determine whether the sample size is sufficient (Mason, 2010). For a case study, sample size is the least important concern because the researcher should be focused more on the fullness of the data; however, at least one person should be used for a case study design, but more can be utilized (Njie & Asimiran, 2014). Therefore, the sample size for this research study was five social workers to reach saturation. Qualitative researchers must be cautious in their understanding of saturation because the conclusion of the data could prove to be false if the researcher simply believes saturation has been met due to the lack of new findings (Charmaz, 2014). Codes, themes, and concepts were exhausted to reach saturation (van Rijnsoever, 2017). I reached saturation with the sample size of five social workers.

Instrumentation

When conducting any research, there are tools that are utilized to collect the data. In case studies, researchers often use interviews, observations, recordings, and other

communications to collect data; however, the use of semi structured open-ended interviews is most popular (Burkholder et al., 2016). When conducting semi-structured interviews, the researcher must establish questions that are related to the research question(s) and the researcher needs to anticipate probing questions will be needed to follow-up and provide more in-depth reflections from the participants (Burkholder et al., 2016). I conducted interviews as a means to collect data. Patton (2015) indicated that standardized open-ended questions must be cautiously worded and developed, detailed, and outlined to ensure the researcher is asking the participants the same questions, including the probing questions, in the same order, and with the same intensity. There is minor flexibility with the probing questions, but the researcher must record those questions and if appropriate, use those questions again if the opportunity presents itself with the other participants (Patton, 2015). I created interview questions that guided the process and were recorded via the social platform, Zoom Healthcare, application.

Data Collection

After the potential participants agreed to participate in the study, I contacted each of the participants via email to schedule a day and time for the interviews and the interview process was explained. Social workers who met criteria were interviewed via a secured virtual platform, Zoom Healthcare, due to the hospital's restrictions on visitation because of the COVID-19 pandemic. Three of the five interviews were completed during work hours (lunch break), and the other two were completed after work hours at the discretion of the participants. Each participant was asked to commit up to one hour to complete the interview process and to send an email indicating their understanding of the

study, meeting criteria of the study, confidentiality, and access to the study once it is completed. All interviews were recorded utilizing the record feature offered through Zoom Healthcare. The interviews were transcribed within 24 hours of the completion of the interview and the data was analyzed and stored using the qualitative data analysis software, NVivo. The participants were informed of the recording, transcribing, and data and were allowed to withdraw from the interview process if they deemed necessary. None of the participants withdrew their participation. Additionally, I informed the participants they can have access to their interviews after the study. The interview guide can be found in the appendix.

Data Analysis Plan

After the data was collected, I analyzed the data appropriately by utilizing thematic-narrative analysis, which surfaced a deeper understanding of the views of the participants that were not unearthed applying the traditional means of analysis (Green et al., 2015). There are six steps to thematic-narrative analysis, which include:

1. becoming familiar with the data by reviewing the entire data set several times to ensure that the researcher is fully aware of the collected data;
2. creating the preliminary codes that are basic and interesting to the researcher;
3. extracting the themes by collating the different codes to find the commonalities;
4. looking at the themes from a deeper perspective to ensure that each theme is clear and heterogenous in nature;

5. defining the themes by writing an analysis of the findings for each heterogenous theme that was extracted from the data; and
6. finalizing the written analysis (Braun & Clark, 2006).

After all of the data was collected, I transcribed the interviews and started the coding process. Coding qualitative data requires the researcher/interviewer to allocate a word or brief phrase that summarizes the data collected during the interview or observation (Saldaña, 2016). To code the data, I utilized NVivo coding software, which captured the voice of the participants and utilized verbatim what was communicated (Saldaña, 2016).

Issues of Trustworthiness

Trustworthiness is a vital part of research because it determines the integrity of the study. To meet the expectations of trustworthiness, I outlined the steps that were implemented to ensure the study was trustworthy and can be an addition to research that has already been established and what is yet to come.

Credibility

Credibility focuses on the value of the truth of the study (Elo et al., 2014). For this study, credibility was attained by utilizing member checking to ensure what was being conveyed in the study was truthful from their perspective. The participants did not feel the need to review their transcripts, but it was offered. Engaging in member checking strengthens the data because it allowed the data to be analyzed and discussed from the perspective of the participants and the researcher (Caretta & Pérez, 2019; Korstjens & Moser, 2018). Additionally, member checking is considered one of the most critical

techniques to establish credibility (Amankwaa, 2016). It was necessary for me to utilize persistent observation as a means of reviewing the codes and recoding as necessary in an effort to hone in on details that arose from the data that impacted the problem outlined in the study (Korstjens & Moser, 2018). Lastly, due to the restrictions of the COVID-19 pandemic, policies and procedures were not readily available to the researcher; therefore, triangulation was not used.

Transferability

To ensure this study is generalizable in other settings and can be replicated if necessary, I provided a detailed description of the setting, the participants' demographics in relation to the content being collected, including the inclusionary and exclusionary criteria of the participants, the sample size, the interview guide that was approved and used, a detailed outline of the how the interviews were conducted, and an overview of the transcriptions that were used to collect the data. By utilizing the aforementioned details, transferability was attained (Amankwaa, 2016; Korstjens & Moser, 2018).

Dependability

Being consistent throughout the research study, from the development of the interview guide to how it was implemented, was vital because it determined whether the study was dependable (Korstjens & Moser, 2018). Since this study used an interview guide, to maintain consistency, the same questions were asked of each participant and was recorded to ensure the interviews were implemented in the exact manner for each participant. Furthermore, this determined whether the data collected was consistent with the written findings (Amankwaa, 2016).

Confirmability

Confirmability focuses on whether the findings are a truthful analysis of the data and not skewed by the researcher's biases or what they thought the findings should be (Connelly, 2016). To strategize how confirmability was established and maintained, I used an audit trail to collect all of the details that were used to implement the study, including maintaining a researcher's journal to outline any feelings and possible biases that may have arisen because of the researcher's previous position as a social worker in a psychiatric hospital. The journal assisted the researcher in maintaining objectivity in the data collection and analysis.

Ethical Considerations

Ethical considerations assist the researcher in the prevention of misrepresenting the data, thus causing skewed findings and includes confidentiality and social responsibility (Prabhakar, 2013). Ethical considerations include confidentiality practices, consent, privacy, and any conflict of interest. To protect the confidentiality of each participant, they were given a personal identification number and the demographics exposed were just gender and years of service. All documentation and data are only available to the faculty of Walden University, as requested, and myself. All computer or web-based data was downloaded onto an external hard drive that was password protected. I will maintain the data for five years in a locked cabinet in my home office until it is deemed appropriate to destroy.

Once the data was collected, I became familiar with the data by listening to the recordings several times and comparing it to the transcriptions that were developed to

ensure accuracy and it was understood what the participant was trying to convey in their answers. I wanted to ensure interpretation of the participants was accurate. After reviewing the interviews and comparing the transcriptions, I began to create the basic codes found in the data by analyzing the codes that came from that analysis. I pinpointed the themes that arose from the collected data and analyzed those themes to ensure each theme was concise, diverse, and was able to stand alone. Lastly, I wrote the final analysis and conclusion of the data as it was interpreted through the themes. I provided a means of obtaining the final, approved findings to the participants if they would like to read the full study. I will maintain the data for a minimum of five years and dispose of it according to the federal laws of Virginia after that timeframe.

Summary

This qualitative research study attempted to explore the experiences of social workers in a state, psychiatric hospital and the influences it has on patients. I conducted interviews to collect data, coded said data, and stored it via NVivo coding software. I made every attempt to ensure the trustworthy strategies were used throughout the research process.

Chapter 4: Results

The purpose of this qualitative case study was to gain an understanding of how the systemic, professional experiences of social workers in a state, inpatient psychiatric hospital influences the treatment delivery of patients. The goal was to address the research question related to experiences of social workers and how the system of the psychiatric hospital may affect patients, as social workers often work in stressful environments with high expectations for quality support to patients (Wagaman et al., 2015). This qualitative case study explored the viewpoints of five social workers who are currently employed by a state, inpatient psychiatric hospital through interviews utilizing open-ended questions. The interviews were conducted until saturation was reached. Saturation is reached when no new codes, concepts, or themes are generated (Rijnsoever, 2017). This chapter outlines the themes that emerged from careful analysis of the data collected. To this end, Chapter 4 delineates the findings uncovered by the research question.

Setting and Demographics

I received approval from Walden University's IRB on August 12, 2020 (IRB approval #08-12-20-0706079) to conduct research. I also had to obtain approval from each hospitals' internal research review committee per hospital protocol. This included completing and submitting documentation provided by each committee. Approval was obtained from the hospitals' committees, and I had to gain permission from the social work departments' supervisors to interview their staff. Each supervisor was sent an email from me explaining the study with the university's IRB approved flyer and consent form

attached. The supervisors were asked to disseminate the email, flyer, and consent form to their staff by way of their internal email system.

Participants contacted me via email to schedule their interviews. All interviews were conducted using the virtual platform, Zoom, because of the state and hospital restrictions due to the COVID-19 pandemic. Participants reviewed the consent form and gave consent when they scheduled their interviews by email. While scheduling and conducting the five interviews, each participant received a pseudonym to protect their anonymity. Each participant in the study were identified by the initials "RP" to represent "research participant" followed by a sequence of numbers (e.g., RP001). At the time of the study, all five participants were employed as social workers at the psychiatric hospital and met criteria for the study. Of the five participants who volunteered for the study, none were males and five were females and averaged 4.5 years of service (see Table 1).

Table 1

Demographics

Participant	Sex	Years of Service
RP001	Female	3
RP002	Female	6
RP003	Female	4
RP004	Female	4
RP005	Female	4

Data Collection

Initially, I attempted to conduct the research at two hospitals. After approval from the hospitals' research committees, both social work supervisors were contacted by email. However, after four communication attempts, one of the supervisors did not

respond to the request to conduct the research. Therefore, that hospital did not yield any participants. After emailing the social work supervisor at one of the hospitals, it took 2 weeks for a response by way of email and a phone conversation. But within 2 days of the email being forwarded to social workers by the supervisor, the first interview was scheduled, and all subsequent interviews were scheduled and completed within 3 weeks.

Originally, the interviews were planned to be face-to-face; however, due to the COVID-19 pandemic, the hospital restricted visitation for the safety of the staff and patients. Four of the five interviews were conducted through Zoom video chat, and one was conducted by Zoom phone chat. Each participant agreed to be recorded and verbally consented to be interviewed. Prior to the start of the interview, participants were reminded the interview was voluntary and they could stop at any time if they felt uncomfortable. Two of the five interviews were conducted after business hours per the request of the social workers, and the remaining interviews were conducted during the social workers' lunch break. One interview had technical difficulties as the participant's phone connection failed toward the end of the interview. But once phone connection was restored, the interview resumed with no further interruptions.

After the interviews, the data were reviewed for accuracy, content, interpretation, and possible saturation. After careful review of the collected data, it was determined that saturation was attained as no new themes emerged.

Evidence of Trustworthiness

Credibility

Credibility focuses on the value of the truth of the study (Elo et al., 2014). For this study, credibility was attained by attempting to utilize member checking to ensure what is being conveyed in the study is truthful from their perspective. Each participant was given the opportunity to review their transcripts; however, none of the participants chose to review their transcripts. Although member checking is one of the most critical techniques to establish credibility (Amankwaa, 2016), the participants were certain their responses were being conveyed as they were communicated during the interview process. I also utilized persistent observation as a means of reviewing the codes to hone in on details that emerged from the data (Korstjens & Moser, 2018). Finally, I had no affiliations with any of the participants.

Transferability

Transferability is the extent to which the findings can be transferred to other settings, conditions, and populations, which is provided by the researcher through thorough and vivid accounts of the participants and context of the study (Connelly, 2016). To ensure this study is transferable in other settings and can be replicated if necessary, I provided a detailed description of the setting; the participants' demographics in relation to the content being collected, including the inclusionary and exclusionary criteria of the participants; the sample size; the approved interview guide utilized; a detailed outline of the how the interviews were conducted due to the restrictions of COVID-19; and an overview of the transcriptions that were used to collect the data.

Though transferability can be achieved in future research, it is to the discretion of the researcher to decide whether they would fully replicate my study.

Dependability

Consistency throughout the research study determines whether the study is dependable (Korstjens & Moser, 2018). Additionally, dependability is achieved by ensuring the collected data are consistent with the written findings (Amankwaa, 2016). This study used an interview guide to maintain stability throughout the interview process. The same questions were asked of each participant and each interview was recorded through the virtual platform, Zoom, due to the visitation restrictions set forth by the hospital due to COVID-19. The final question of the interview allowed the participants to add any information they deemed necessary or relevant to the research study.

Confirmability

To strategize how confirmability would be established and maintained, I used an audit trail to collect all of the details that were used to implement the study, including maintaining a researcher's journal to outline any feelings and biases that could possibly arise due to my previous position as a social worker in a psychiatric hospital. The journal was effective in maintaining objectivity in the data collection and analysis. I remained objective throughout data collection and analysis; therefore, a peer was not needed to collect the necessary data. Conformability was established, as the findings are a truthful analysis of the data, which are free of researcher biases (Connelly, 2016).

Data Analysis

Utilizing the interview guide approved by the IRB (Appendix), I interviewed five social workers employed by a state, psychiatric hospital to gain an understanding of how their professional experiences may influence the treatment delivery of the patients. All interviews were recorded via Zoom and securely saved on my computer's hard drive, which is password protected. The interviews were transcribed, managed, and stored using the computer-based software, NVivo. Thematic-narrative analysis was used to analyze the data. This type of analysis is popular with case studies as it allows the proposed phenomenon to emerge as it is experienced by the participants (Sahito & Vaisanen, 2018). Additionally, thematic-narrative analysis allowed me to address any commonalities in the interview process and focus on the content (Belanger et al., 2018). When applying thematic-narrative analysis, there are six steps when analyzing the data. I employed all the steps carefully to ensure the appropriate themes were extracted.

Codes, Categories, and Themes

After listening to the recordings and reading the transcripts multiple times, codes were identified. Coding occurs in cycles starting with broad words or phrases and ending with longer passages to assist with defining the themes (Saldaña, 2016). After the codes were identified and analyzed, five diverse themes emerged: (a) insufficient time spent with patients, (b) prioritization of discharging patients and frequent hospitalizations, (c) the levels of support throughout the system, (d) the potential for burnout and job performance, and (e) interactions with patients and commitment to service. Table 2 outlines and interprets each theme and provides evidence of how the theme emerged.

Thematic Analysis

Insufficient Time Spent with Patients

After careful review of the data collected, insufficient time spent with patients was a theme that frequently emerged. All the participants described their responsibilities as a social worker in the hospital as vast, and there is limited time to build an appropriate rapport with the patients. But rapport building is necessary, especially since one of the main responsibilities is discharge, planning and linking the patients to services in the community once they are discharged from the hospital. According to the participants' interview responses, there is a link between the responsibilities of the social worker and how they view their experiences as a social worker in the hospital. RP002 alluded to the vast responsibilities by stating,

> My responsibilities involve receiving calls from the community, the community services board, sometimes other hospitals to collect data or to collect case information about the patient to determine are they appropriate to come to the hospital on a TDO [temporary detention order] admission. And that may be involved getting medical clearance. It may involve phone calls back and forth with CSBs [community service board]. And then I kind of walk someone through the admission process. So that's primarily what I do. I also do social work assessments, clinical assessments for patients once they're admitted and they're on the wards, then I will do that. I do coverage for social workers that might be sick or unavailable. I might cover treatment team. Today, I covered court for one of the social workers. So, there's always coverage involved. And then the last

> thing is the UAIs [uniform assessment instrument] which are an 11-page assessment that's done when someone needs placement in the community in adult living facility or a nursing home. And so, I complete those as well. So, I kind of have an array of duties.

Regarding the limitations of building a healthy rapport with the patients due to the level of responsibilities, RP001 indicated, "We are sadly understaffed and overcrowded. And I have 31 patients on my ward. But you really can't, to some degree, you can't really do anything except just put out fires all day when you're worked that hard." Additionally, RP004 stated, "The worst part is that, as time goes by, you realize how limited you are in what you can do, and that gets amazingly frustrating."

All five participants expressed their responsibilities were vast, but all of it has been a learning experience, whether good, bad, or indifferent, that assists them with doing their jobs effectively. RP003 stated, "So it's been a learning experience. I learned a lot, which has been good. I have also had negative experiences." RP004 described her experience as a social worker as:

> It's a good and bad thing. It's good because most folks who go into social work want to work with underserved populations. So, you have lots of opportunity to meet people at the absolute lowest point, and try to use what resources you have to help them along. So that feels really good keeping with your mission as a social worker.

In conclusion, this theme reflects the many nuances of the role of the social worker in the psychiatric hospital and how their experiences are birthed from it. Although

the responsibilities are immense for the social workers, they view these tasks as a learning experience which ultimately assists with how they interact with the patients.

Prioritization of Discharging Patients and Frequent Hospitalizations

A common theme emerged in the data surrounding the prioritization of discharging patients. All five participants expressed discharging patients was a primary role in their job responsibilities. There were references by all of the participants of the priority to discharge patients despite their recommendations and the patients' readiness to be discharged from the hospital. For example, RP002 stated, "There's one set of experiences with—there's been a lot of pressure on social workers in state hospitals to discharge because since the legislation there has been a huge upswing in TDOs [temporary detention order] that have come into hospitals on the civil side of our hospital." RP001 and RP003 had similar sentiments regarding the prioritization of the discharges. RP003 responded,

> I think there's an expectation that we discharge people as quickly as we can. And I think that we're trying to do that, but unfortunately there is a partnership with the community service board, and to discharge patients in a placement that doesn't exist. There have been discharges that I have done that, even though I've been able to constantly supervise, I'm not entirely comfortable with where the patient is going or the outcome, because I feel that they've rushed, and it is typically to discharge someone to bring someone in. I've been in a meeting where there was a patient who had been rehospitalized maybe three times within the month, and at one point they said that the patient was wasting an acute bed. And

> that was really kind of hard and discouraging, because they kept coming back, obviously something was not working in the community and we needed to work harder to figure out what was going on before we sent them out again, because we had seen what happens when we let them out prematurely.

Regarding the readiness of patients to be discharged from the hospital, RP005 provided context by stating, “I think our goal is to discharge people and set them up for success the best we can. Sometimes my values kind of conflict with that because sometimes we’re just trying to get people out. We need to reduce the census. We got to get people out.” Equally, RP004 expressed, “It’s like people come up with these crazy ideas about how to proceed with this person, or how to discharge them and we’re like, ‘Are you living on another planet?’ Yeah. So, yeah. I just couldn’t stress it enough.”

Three of the five participants described an incident where they were pushed to discharge a patient despite their readiness and how the push was simply to keep the census down and have the availability of beds for those individuals who need treatment. This speaks to the frequent hospitalizations of the patients when they are forcing them out of the hospital. RP002 described this phenomenon by expressing, “And the system is really kind of stretched and not always able to meet those needs. And so sometimes what we see is the patients that come back to the hospital pretty quickly.”

The emergence of this theme relates to the expectations of the social workers by hospital administration. Based on the data collected, I determined that social workers feel the push to discharge patients even when they are faced with circumstances where they disagree with the timing or readiness of the patients. Additionally, this theme aligns with

the literature regarding frequent hospitalizations and length of stay. Pauselli et al. (2017) linked frequent hospitalizations and length of stay in the hospital with those living with mental illness.

The Levels of Support Throughout the System

Concerning the questions on the understanding of systems, each participant was very clear on what systems were and how they manifested themselves in general and in the hospital. When explaining their views on systems, RP004 indicated:

> I mean, I think my eyes have even been opened more over the past year in understanding what systems really do play a part in people's lives. It's everything. It's where they grew up. It's what kind of schooling they've had. It's what kind of treatment they got provided. It's whether they land here or not. Who gets accesses to what resources when they get out of here? It's just I couldn't even begin to-- it's everything.

Equally, RP003 stated, "So I think that systems are the social workers that are on the floor per se, and then there's supervisors, and then above them is our director. And unfortunately, I think there is a disconnect sometimes between what the director tells us and asks of us, as opposed to the reality of what is happening on the ground level with the direct patients."

Participants described feelings of support from their primary system, which included their direct team and supervisor; however, that same support was not experienced from the system described as the hospital and the administration. RP005

suggested, “I don’t really feel like I have the support of the hospital when it comes to certain placement options.” RP001 had similar remarks:

> It doesn’t really support it all that well. I mean a lot is expected of us but we aren’t given a lot of the kinds of support that would be the most valuable. So really the number one thing that would make our job a lot easier would just be to have more of us, to not have such massive caseloads and just that would enable everybody to work more efficiently and do a better job on individual cases.

Contrary to what the other participants expressed, one participant suggested there was a level of support from the hospital’s administrative team. RP004 commented,

> Okay. Well, the expectations of the hospital as a system are to treat individuals, hopefully, with best practices, and to get them out as quickly as possible. Now, it aligns absolutely it aligns, because as a social worker we do want to provide good treatment, and we do want to help return people to the community. But I’ve noticed a shift, and I’m not saying it’s good or bad, it just is.

RP002 had similar sentiments regarding the support of the system. She expressed:

> Well, they kind of conflict a lot of times with the administrative system and they-- I think my social work role and my values and how I carry it out works well with the patient and works well with direct service staff and nursing, the people that I interact with every day. But sometimes in my role as an advocate, for the patient and for staff, can rub up against administration and that kind of overarching system because there may be certain things regarding staffing that I might be trying to advocate.

Systems theory was derived on the premise that everything in this world (people, places, and things) belong to a system which is then broken down into smaller systems that work together to make a whole system (Caws, 2015; Rousseau, 2015). Therefore, the findings reveal this is an accurate account of what systems are and how the larger system affects how the smaller system operates and vice versa. RP002 proved this was the case by expressing:

> It brings that up to a very high level. It does because I mean if I feel like my direct line of command is hearing when I bring up concerns, and they're hearing when I bring up ways we can do this better and they're following through, then I can relax and I can settle into my job, and I can do the best work I can do as a social worker because I know administration is handling kind of these other issues that are coming up, which I guess are in some ways they're system problems.

The Potential for Burnout and Job Performance

Hussein (2018) highlighted social workers engage with those that have experienced trauma, abuse, poverty, and other life altering events which causes social workers to have an unprecedented level of stress and burnout than any occupation in the human services field. This was confirmed in the responses outlined by the participants. RP001 commented:

> The other piece of it is the burnout factor and the-- I mean to be perfectly honest, it's extremely dangerous at hospital right now. And also to be fair, I get pretty burned out sometimes and I think somedays I'm just not capable of putting the effort in. So that stress builds and builds and builds on itself and kind of makes

> me less of a hard worker sometimes because it feels so overwhelming. So, my performance declines a little bit. I am usually very, very thorough and want to take time to make the best decision and consulting other parties and figuring out what can be done, but all of that takes time. So, when I'm rushed and I have to juggle a bunch of patients, the performance is not as good as I would like it to be simply because it can't be.

According to the participants' responses, stress and burnout was a direct correlation to whether they felt their job performance was affected. RP003 stated, "So how it affects my job performance-- I think it's kind of complicated, because there are times where what the hospital needs is greater than, I guess, my needs." RP004 followed up with a comparable statement:

> It's easier to get discouraged, I think. And when you get discouraged, you tend to—the stress comes out in your work. It does. You may not be as creative as you normally would because when you're stressed, you're not particularly creative. You may not be going that extra mile when—and I guess that's part of the creativity because when you work with folks here, you've got to think creatively because they didn't come here because they were easy clients.

As outlined by Savaya et al., (2018) and Tartakovsky (2016), personal accomplishment that is viewed as being low often makes the employee have feelings of unhappiness with their professional growth and have an overall undesirable insight of their job. Therefore, the development of this theme is congruent with the literature.

Interactions with Patients and Commitment to Service

According to all five participants, interacting with the patients and being committed to servicing them despite the obstacles they face within the system was a recurring theme in the data. There were mixed reactions about their interactions and how it correlated with their professional relationships with the patients. Some participants felt their interactions were positive. RP005 described her experience as,

> I'm a little bit of a rebel, so I'm here for the patients first I'm just like, "You're going to get what you're going to get and that's how it is first and foremost." I don't get to choose my patients. Never thought I would be able to when I got into the field, so I work with everybody on every different level.

Correspondingly, RP002 revealed, "I feel like I'm doing some clinical work, but I'm also doing kind of the work which is the advocacy and the roots of social work and trying to make things better for the patient, ultimately."

Other participants expressed how difficult it can be to interact effectively with the patients due to their lack of patience and feelings of being overwhelmed. RP004 suggested:

> I'm sure it probably does come out. Maybe I don't even like to admit that it comes out. I feel like I come and I give it my all. I try very hard to provide a good service to people. But when you're feeling really overwhelmed and frustrated, it's going to come out even if you think it's not. I mean, just part of being a self-aware clinician, you know it's got to come out when you're feeling overwhelmed. And if you had all the support that you feel like you need, I don't think we would

> feel as overwhelmed as often. So yeah, I think it probably makes you a little shorter-- not short temper, but a little less patient.

RP003 also had an analogous assessment of the difficulties they have with interacting with their patients. She stated:

> I feel that there are times where I have, unfortunately, been less patient with patients when I know that the end goal is discharge, or if I know that I'm just going to have to try and discharge them, regardless of my personal feelings, that I have to take less of an interest—I don't think interest is the right word, but kind of a step back and knowing what my feelings may be about it.

I determined that building a rapport with the patients and remaining committed to servicing the patients were areas the participants felt strong. Whether they felt like it was a difficult task due to their own personal feelings, moving through their feelings to ensure the patients were served efficiently.

Overall, in review of the data analysis, I would surmise there are concerns with how the system is responsible for how the social workers interact with patients and their perceptions of support from the system in comparison to patient treatment. However, there is a commitment to remain person-centered and serve the patients from a holistic approach although that may not be the full agenda of the system.

Table 2

Themes, Interpretation, and Evidence

Themes	Interpretation	Evidence
Insufficient time with patients	In review of the data, social workers had a lot of responsibilities, which impeded their time with patients.	RP001 indicated not having adequate time to spend with patients and to build rapport to achieve the goals of effective discharge. There are limitations in what they can do with patients because of the level of responsibilities.
Prioritization of discharging patients and frequent hospitalizations	The data were clear that the priority for the social workers was to discharge patients within a timeframe often not conducive to the treatment modalities of the patients, thus causing frequent hospitalizations.	RP004 discussed the frequent hospitalizations being a factor when the patients are not ready for discharge. Due to discharge being a priority, there is a strain on the social workers and patients.
The levels of support throughout the system	Participants revealed how they felt support from their immediate teams and supervisor but did not have the same feelings of support from the hospital as a system	All participants felt some support from the smaller system. RP005 revealed feeling limited support from the hospital as a system due to the expectations.
The potential for burnout and job performance	Due to the job responsibilities and discharge priorities, the possibilities of burnout were higher, and their job performance was affected.	All participants expressed the levels of stress they endure, which could lead to burnout and the adverse effects it has on their job performance.
Interactions with patients and commitment to service	Participants expressed the importance of positive interactions with patients and being committed to servicing them.	RP005 noted her commitment to servicing because that is her top priority despite what is expected of them.

Summary

In this chapter, I attempted to gain an understanding of the systemic, professional experiences of the social workers in a state, inpatient psychiatric hospital. The setting and demographics, data collection, evidence of trustworthiness, and data analysis were critiqued. Based on the analysis of the data, five distinct themes were extracted and discussed. Chapter 5 will give me the opportunity to describe the interpretation of the findings, limitations of the study, recommendations, and implications of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative case study was to gain insight of how the systemic, professional experiences of social workers in a state, inpatient psychiatric hospital influenced the treatment delivery of patients. The five themes that emerged from the data were (a) insufficient time spent with patients, (b) prioritization of discharging patients and frequent hospitalizations, (c) the levels of support throughout the system, (d) the potential for burnout and job performance, and (e) interactions with patients and commitment to service. One of the key findings extracted from the study was the prioritization of the discharge and the direct correlation of frequent hospitalizations. All five participants indicated that their top priority was discharging patients even when there was evidence the patients were not ready to be discharged. Consequently, this contributed to the frequent hospitalizations for those patients who were not ready to be discharged, which was the problem outlined in this study. From these results, discharge planning is the ultimate motivation of the hospital as a system but not necessarily the views of the social workers. This chapter will focus on the interpretation of the findings, limitations of the study, recommendations, implications, and the conclusion.

Interpretation of the Findings

In correlation with what was outlined and cited in Chapter 2, an examination of how the systemic experiences of social workers in a state, inpatient psychiatric hospital influence treatment delivery of patients will be presented in this chapter. The study extracted the following five themes: insufficient time spent with patients, prioritization of

discharging patients and frequent hospitalizations, the levels of support throughout the system, the potential for burnout and job performance, and interactions with patients and commitment to service. The findings of this study confirmed that the psychiatric hospital, as a system, is a direct correlation of how effective the social workers are in their service delivery to the patients.

Insufficient Time with Patients

Being a social worker is a highly stressful occupation due to liability, guidelines, increased documentation, and the push to assist individuals achieve their short and long-term goals outlined in the written treatment plan (Acker, 2018). According to the National Association of Social Workers (2019), social workers practicing in the mental health arena focus on the diagnostic, assessment, and treatment needs through individual, family, and group therapy. All five participants confirmed this to be true as they delineated their job responsibilities. There was relatively little research on social workers in psychiatric hospitals and their experiences; however, the studies that surfaced focused on the need of mental health social workers on multidisciplinary teams to provide the necessary psychoeducational needs, assessments, and working with individuals and families from a holistic approach (Yusof et al., 2019), and mental health social workers in community mental health settings are beneficial to recovery-oriented care of patients (Courtney & Moulding, 2014). However, RP001 expressed,

> I don’t have enough time to spend with my patients, building rapport and really doing a lot of the clinical work that I feel social workers can really bring to the table in these types of settings. I don’t really necessarily have the time to spend on

> the phone with all these different family members and everything. Whereas in an ideal environment I would like to do a much better job of that, but I have to prioritize.

This theme and the aforementioned studies suggest the responsibilities that are required of the social workers are vast and necessary; however, these responsibilities often cause the time the social workers have with patients to be insufficient.

Prioritization of Discharging Patients and Frequent Hospitalizations

At least 40% to 60% of patients are hospitalized again within 1 year after their initial discharge (O'Connell et al., 2018). It is unclear why the recidivism rate remains high among those who have been admitted into an inpatient psychiatric hospital; however, participants assessed that the push for discharge when patients are not ready and ineffective resources in the community could have a major impact on why the recidivism rate has increased. RP002 described this phenomenon by expressing, "And the system is really kind of stretched and not always able to meet those needs. And so sometimes what we see is the patients that come back to the hospital pretty quickly." RP005 had similar sentiments when describing the recidivism rate in relation to discharging patients prematurely. She indicated,

> We got to work with the CSB [community service board] and get them out. Well, sometimes they're not really ready to go. I wish that we would do more individual therapy. That's kind of one of the systemic issues that I see here, is that we want people in and out, in and out. They come in and we want them out, because we know that really the best thing for people is getting services in the least restrictive

> environment but they're not getting that all the time. And especially right now, no one is getting any kind of—or very few services in the community.

This aligns with the studies Pollack et al. (2018) and Pauselli et al. (2017) conducted regarding rehospitalization and length of stay at the hospital, respectively.

Levels of Support Throughout the System

Ultimately, systems theory is devised on the premise that everything in this world (people, places, and things) belongs to a system, which is then broken down into smaller systems that work together to make the system whole (Caws, 2015; Rousseau, 2015). Systems theory surmises that the roles and expectations of the system has an impact on the individuals involved within the system (Bethea & McCollum, 2013). Individuals are part of the whole; therefore, the organization should be viewed as a whole and not the individual as just a "part" (Von Bertalanffy, 1972) The system of human relationships are the cause and effect of human behaviors (Meyer et al., 2013). Although social workers can be viewed as a system on their own, this framework assisted me in considering the hospital as a system and how social workers were interconnected into that system.

Participants communicated their understanding of systems and how they did not feel supported from the larger system, which is the psychiatric hospital. RP002 confirmed the interconnectedness of systems by stating,

> And then I think overriding, there's the hospital system, the administration that is trying to go forward with running this hospital and really trying to do kind of the best they can with a limited budget. And so, people in the other systems may not feel completely appreciated because they're maybe not getting paid what they

> want to get paid. So that can kind of be a struggle sometimes in a hospital. And their commitment is to kind of follow what hospital administration wants them to do which may not always kind of be the best—might be the best for the patient I guess, but for staff, they can really be stretched sometimes. So that's kind of, I guess, the things that can happen kind of systems while in the hospital that impacts the patient.

From a theoretical standpoint and according to the interviews with the participants, the hospital is a system, and there are smaller systems within the larger system; however, despite the level of systems, each individual within the system is impacted by the decisions made within the system. Social workers have to feel like they have support of the organization employing them by including them in the decision-making processes, proper supervision, and a culture for learning (Hussein, 2018).

Potential for Burnout and Job Performance

Burnout can affect any person in any profession and is defined as a person's response to the pressure and stress of their occupation (Marc & Oşvat, 2013). Job stress, high demands, consistent documentation, high caseloads, inadequate wages for the workload, lack of proper supervision, hopelessness surrounding personal goals, and detachment from human emotion are some of the reasons why social workers are at a high risk for burnout (Kim & Ji, 2009; Lanham et al., 2012; Travis et al., 2016). All these concerns were in some way expressed by each participant in the study. The demands of the job, coupled with the lack of support from the system, often brought on feelings of burnout. As highlighted in a quantitative study conducted by Hussein (2018), the burnout

of social workers is directly related to how they perceive their work environments, the resources available to them, and the demands of the job. This is congruent to what the participants described and how this theme emerged. While the participants did not utilize the Maslach Burnout Inventory instrument in this study, some of the participants described feelings of low personal accomplishment. The low personal accomplishment is a direct reflection of how they view their job performance. Three participants described how all of the job responsibilities, lack of support from the system, and not having enough time to accomplish the tasks affected how they performed their job; ultimately, affecting interactions with the patients. RP001 was very vocal about being overwhelmed and at times, not being able to complete tasks during the work day. Because those living with mental illness are viewed as vulnerable, stigmatized, and often a misunderstood population, social workers that provide services to them are at a higher risk of emotional fatigue; thus, causing a higher level of burnout and stress (Bove & Pervan, 2013; Hussein et al., 2014a).

Sofology et al (2019) conducted a quantitative study which concluded that mental health workers, including social workers, had a higher significance of emotional exhaustion and personal accomplishment and there was a direct correlation with workers' length of time on the job and emotional exhaustion. Emotional exhaustion was higher the longer the worker stayed on the job. This level of emotional exhaustion led to insufficient job performance (Sofology et al., 2019). However, this study could not conclude the same outcome as the aforementioned study as the participants years of service averaged

4.2 years. Additionally, the participants did not express any feelings of emotional exhaustion.

Interactions with Patients and Commitment to Service

Social workers play a vital role in the care and treatment of individuals because they treat them holistically on micro (individual) and macro (environment and natural supports) levels. Karban (2017) explained that treating the individual holistically is often subordinate to treating them with medication, which should be done simultaneously for the success of the individuals' treatment. Sohn and Jang (2019) studied the experiences of social workers and the collaboration with outside agencies and disciplines to treat those living with mental illness. The outcome of the study revealed that collaboration with outside agencies was substandard, there was a lack of resources to achieve optimal job performance, and the need for a unified system that fostered more collaborative efforts. The participants in this study discussed the lack of resources necessary to assist the patients during their tenure in the hospital and once they are discharged from the hospital, the ineffective communication with the agencies that assist with the treatment of the patients, and the need for the system that was more tolerable and gave them what they needed to complete their job tasks. Although the social workers do not have what they need to be fully effective in their responsibilities, they asserted that it did not prevent them from giving the patients what they needed in their treatment modalities and they were committed to serving them as effectively as they system would allow. The barriers to treatment were there, but their commitment to the field of social work and the patients they served did not waver.

Yerushalmi (2017) indicated that social workers who professionally interact with those living with mental illness often experience impairment with dealing with the challenges that come with the therapeutic relationship; thus, potentially causing social workers to adversely affecting the treatment modality, the manner in which social workers interacted with individuals, and countertransference of negative emotions. These findings in my study counter the findings of Yershalmi. The participants did not experience challenges with the therapeutic process, but with the amount of time they have to dedicate to the therapeutic process.

Limitations of the Study

The first limitation to this study was the sample size. This study utilized a case study approach, which can yield one or multiple participants with shared commonalities in one setting. I attempted to have multiple hospitals participate in the study, but only one hospital yielded participants. While I saturated at five participants, this sample size may not be large enough to effectively address transferability in future research. Although not purposeful and not a criterion for this study, the participants identified as female. Hence, this study cannot draw any conclusions on social workers who identify as male. Only having female participants gave perspective from that gender demographic. It is a possibility that male social workers could have a different experience than female participants. Future research that included male participants could lend a viewpoint that was not highlighted in this research study.

Another limitation of the study was all social workers were employed by a state, inpatient psychiatric hospital. Social workers are employed in many different settings, but

this study was specific to a state, inpatient psychiatric hospital. Social workers in different settings may not have the same responsibilities or experiences as social workers in a state, inpatient psychiatric hospital. Social workers do not simply work with individuals living with mental illness, but they work with children, families, and in settings that may be more administrative in nature; consequently, decreasing the generalizability of the study findings. In future research, the researchers could possibly broaden the setting to general health hospitals and other settings that have a mental health ward and a shorter length of stay for the patients.

Recommendations

As social workers become more involved in the growing need for mental health services and the mental health initiatives that are being implemented in the face of this pandemic, future studies should include social workers from all hospitals and settings that offer mental health services. Those studies should focus on a larger sample size to yield findings that were not apparent in this study. Additionally, future studies should include demographics that could possibly unearth findings related to certain demographical categories such as gender, years of service, or locality (urban, suburban, and rural).

With the system-driven prioritization of discharge and the influx of frequent rehospitalization within a year of discharge, further research would be beneficial that addressed the systematic views of business-oriented decisions versus the health and safety of those living with mental illness. Although the study conducted by Pauselli et al (2017) recommended brief mental health hospital stays as a means to focus on the deinstitutionalization of those living with mental illness, further studies could address the

importance of social workers working with the patients from a holistic approach with the support of the system in an effort to prepare the patients for their care inside and outside of the hospital, what treatment modalities work best to decrease the likelihood of rehospitalizations, and what resources are necessary to ensure proper treatment while in the hospital and when discharged.

Implications

With a careful review of the literature, there was limited research on the systemic experiences of social workers in a state, inpatient psychiatric hospital and in mental health environments overall. There was a plethora of research on social workers in different settings and demographics and the level of burnout they experience, but it was limited research on social workers in mental health settings. This study contributes to the body of literature that focuses on social workers in mental health and how their experiences could be different than those social workers that work in settings that are not geared towards the health and safety of those living with mental illness and its effect on the treatment modalities of the patients.

This research contributes to current and future literature by chronicling experiences of social workers working in inpatient psychiatric hospitals and making strides in possibly changing how social workers are viewed in the mental health arena and how they could affect change in the interactions with patients. The results of this research study illuminated findings that suggest the system (hospital) does have an effect on how the social workers interact with the patients and how those interactions, or lack thereof, affects the treatment outcomes of the patients. With the system pushing for

discharge despite the readiness of patients, there is a concern that treatment is secondary to systematic flow.

From a social standpoint, this study may provide the necessary data for state psychiatric hospitals to make any necessary changes to how they implement practices and the resources that they provide for all direct care staff and the patients. This research may bring more conversation, implementation of mental health initiatives, and changes in the social work and mental health fields. With the rise of mental health issues and the initiatives that are being implemented across the nation, this research study could prove to be a viable tool to affect the change necessary to treat those living with mental illness and provide effective training for those interested in working in the field of social work and mental health.

Conclusion

Yearly in the United States, 1 in 25 (9.8 million or 4%) adults are diagnosed with a serious mental illness, such as schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and post-traumatic stress disorder (NAMI, 2018). Of those 9.8 million individuals, 62.9% receive inpatient hospitalization where they are admitted into the hospital for an extended period of time, other psychiatric services such as outpatient individual therapy, or medication management with a psychiatrist (NAMI, 2018). Social workers are trained to provide a level of care allowing them to focus on psychosocial needs of individuals while simultaneously working with individuals on person-centered goals, objectives, and strategies (Lombardi et al., 2019).

The findings of this research support the existing literature that addresses the lasting effects of not being supported by a system, the level of burnout social workers experience, especially those who work in the mental health arena, how job performance is viewed, and how these concerns ultimately have an impact on the patients served. Despite the aforementioned concerns, social workers continue to provide the services necessary to treat the individuals they serve and are committed to the Code of Ethics outlined by the National Association of Social Workers.

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Appendix: Interview Questions

1. How long have you been a social worker at this facility?
2. What gender do you identify yourself as?
3. What is your understanding of systems and how they influence behavior and experiences?
4. What are your responsibilities as social worker?
5. How do your responsibilities as a social worker align with the expectations of the hospital as a system?
6. How does the hospital, as a system, support your role as a social worker? How does this affect your job performance?
7. What has been your experiences working in this psychiatric hospital?
8. Do these experiences have an effect on how you engage with patients and their treatment?
9. What is your role on the multidisciplinary team?
10. How has your role as a social worker affected the treatment modalities of patients?
11. Is there anything else you would like to share with me?